

Message

From: Poonam Alaigh (b) (6)@hotmail.com
Sent: 11/26/2016 3:14:31 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: [External] Please resend this final attached presentation
Attachments: VHAOrgBrief-PresidentialTransition-DJONES_v2 (002) REVISED Access Team v8.pdf

From: (b) (6) [USA] (b) (6)@bah.com>
Sent: Saturday, November 26, 2016 10:11 AM
To: Poonam Alaigh; (b) (6) (ERPi)
Subject: RE: [External] Please resend this final attached presentation

Poonam,

E-mail 3 of 3. This is a PDF for worse case in case the ppt files aren't working.

Thank you,

(b) (6)

Booz | Allen | Hamilton

(b) (6)

Lead Associate

Mobile: (b) (6)

(b) (6)@bah.com

www.boozallen.com

From: Poonam Alaigh [mailto:(b) (6)@hotmail.com]
Sent: Saturday, November 26, 2016 10:00 AM
To: (b) (6) [USA] (b) (6)@bah.com>; (b) (6) (ERPi) (b) (6)@va.gov>
Subject: [External] Please resend this final attached presentation

██████ I further edited the presentation yesterday and tried sending it to USH. For some reason, he cant open it. Can you see attached and then decompress it or change the format so that he can open it on his personal computer. Call me if you want to talk. Please see attached

Also please send as 2 separate emails- ppx and ppt



VA

U.S. Department
of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing Veterans Health Administration

Prepared for:

Agency Review Team

Briefed by:

David J. Shulkin, MD

Under Secretary of Health, Veterans Health Administration

November 2016

Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
 - Organization, Budget and FTEs
 - Our Mission and Who We Serve
 - Assessment of VHA's Situation
 - Priorities
 - Performance
 - Accomplishments in FY 2016
 - Future Direction, Priorities and Opportunities for VHA

Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

Organization, Budget and FTEs

Organizational Leadership

Veterans Health Administration | Leadership

As of November 14, 2016



VA U.S. Department of Veterans Affairs



David J. Shulkin, MD
Under Secretary for Health



Richard A. Stone, MD
Principal Deputy Under Secretary for Health

Under Secretary for Health
Principal Deputy Under Secretary for Health



Deborah Dort, MD
Deputy Principal Deputy Under Secretary for Health



Barbara Hydeke, MSA
Deputy Chief of Staff



Vivieca Wright-Simpson, MSPH
Chief of Staff



Linda McConnell, MSN
Chief Nursing Officer



Peter Poon, JD, MA
Acting Executive Director, Office of Research Oversight



Michael Fisher, MSW
Chief Readjustment Counseling Officer

Chief of Staff

Nursing

Research Oversight

Readjustment Counseling Service

Operations & Management



Steve Young, MS
Acting Deputy Under Secretary for Health for Operations and Management

Community Care



Baligh R. Yehia, MD
Deputy Under Secretary for Health for Community Care

Workforce Services



Paula Molloy, PhD
Assistant Deputy Under Secretary for Health for Workforce Services

Policy & Services



Jennifer Lee, MD
Deputy Under Secretary for Health for Policy and Services

Finance



Mark W. Yow, MBA
Chief Financial Officer

Organizational Excellence



Carolyn Clancy, MD
Deputy Under Secretary for Health for Organizational Excellence



Steven Lieberman, MD
ADUSH for Access to Care



Thomas Lynch, MD
ADUSH for Clinical Operations and Management



Vacant
ADUSH for Administrative Operations



Regan Crump, MSN, DrPH
ADUSH for Policy and Planning



Vacant
ADUSH for Informatics and Information Governance



Lucille Beck, PhD
Acting ADUSH for Patient Care Services

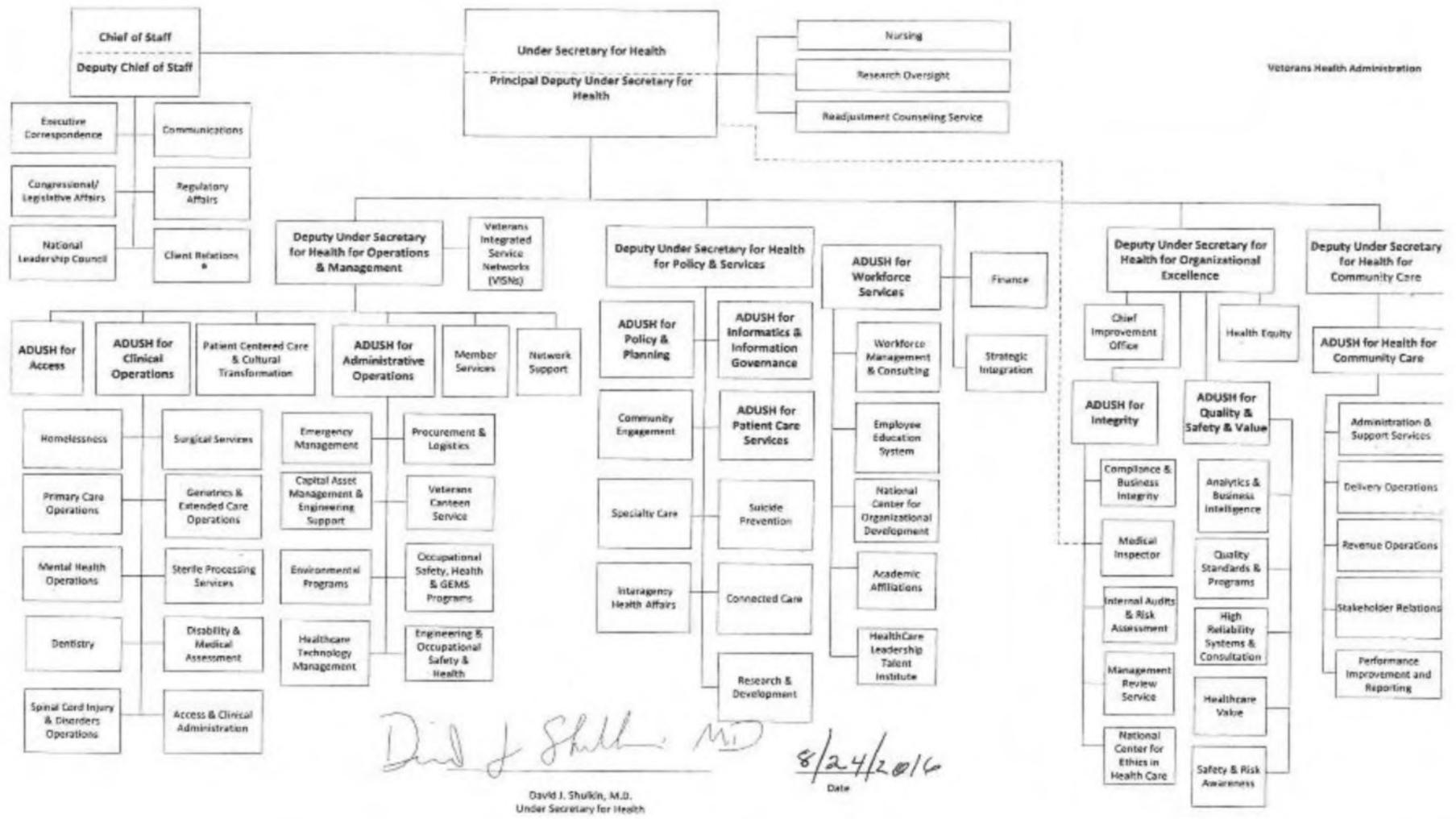


Gerard R. Cox, MD, MHA
ADUSH for Integrity



Robin Hemphill, MD, MHP
Acting ADUSH for Quality, Safety and Value

Organization Chart



Veterans Health Administration

Draft / Pre-decisional / For Internal VA Use Only

Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
\$72,835,537	\$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

VA



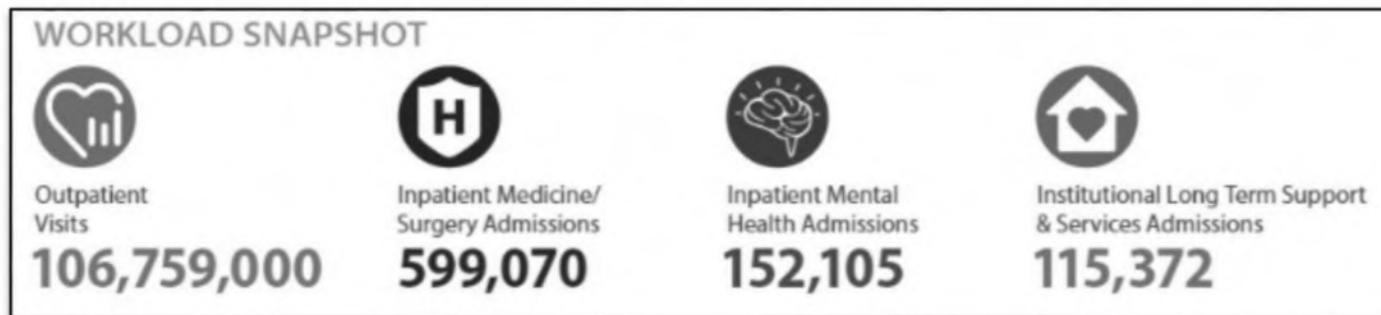
U.S. Department
of Veterans Affairs

How We Are Different: Our Mission and Who We Serve

The Largest Healthcare System in the United States

- 1,234 health care facilities
 - 168 VA Medical Centers
 - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)
- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



VA



U.S. Department
of Veterans Affairs

Who We Serve

- Veterans who rely most on the VA
 - Veterans with lower income
 - Veterans living in rural areas
 - Veterans without other access to health insurance coverage
 - Veterans with poorer self-reported health status
 - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients



VHA's Four Missions

Overall Objective:

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Care Delivery

Develop, maintain, and operate a national health care delivery system for eligible Veterans.

Education

Administer a program of education and training for health care personnel.

Research

Conduct health care research benefitting Veterans and public

Emergency Response

Provide contingency support for Department of Defense (DOD) and Department of Health and Human Services (HHS) during times of war or national emergency

VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

VA



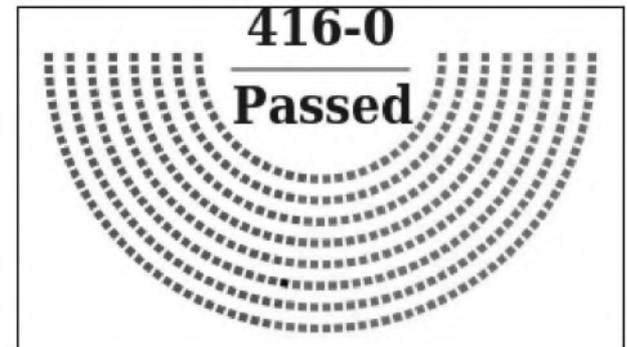
U.S. Department
of Veterans Affairs

VA Healthcare Costs Not Found in the Private Sector

\$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	\$853	\$888	\$924
Camp Lejeune	\$10	\$24	\$21
Caregivers	\$454	\$623	\$725
CHAMPVA, Spina Bifida, FMP, CWVV	\$1,547	\$1,817	\$1,920
Comprehensive Emergency Medical Program	\$147	\$135	\$139
Dental Care	\$1,005	\$1,035	\$1,433
Health Professions Educational Assistance programs	\$37	\$56	\$70
Homeless Programs	\$1,507	\$1,477	\$1,591
Income Verification Match	\$17	\$19	\$19
Long Term Care	\$7,702	\$8,223	\$8,588
Readjustment Counseling	\$221	\$258	\$244
Rural Health Outreach Initiatives	\$219	\$270	\$250
Sharing Agreements - Services Provided by VA	\$157	\$157	\$166
Subtotal	\$13,875	\$14,980	\$16,090
Hepatitis C (assume 50% greater benefit)	\$406.1	\$500.0	\$500.0
Mental Health (assume 50% greater benefit)	\$2,283.9	\$2,494.9	\$2,610.6
Prosthetics (assume 50% greater benefit)	\$909.0	\$950.3	\$1,215.2
Subtotal	\$3,599.0	\$3,945.2	\$4,325.9
Total	\$17,473.9	\$18,924.9	\$20,415.8

20 Years of Increasing Demand for Services

- 1996 “Veterans Eligibility Reform Act”
- Conflicts in Afghanistan and Iraq continued
 - Congress provided eligibility for care for five years after discharge



- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits



- 2014 “The Veterans Access, Choice and Accountability Act”

Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality is equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

VA



U.S. Department
of Veterans Affairs

Impact of VHA Research

VA



U.S. Department
of Veterans Affairs

VHA Priorities

USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

Priority 1: Access Transformative Changes

MyVA Access
Declaration



Prong 1

Prong 2

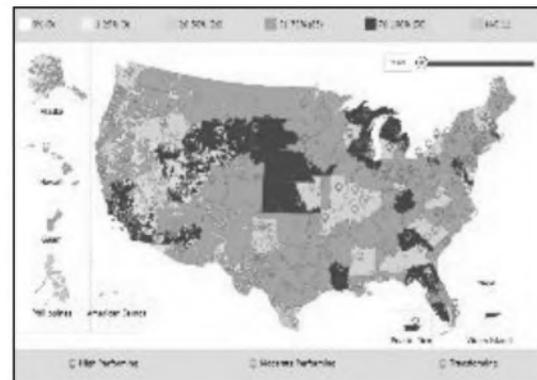
Access
Improvement
Solutions

Prong 3

National
Deployment
Strategy



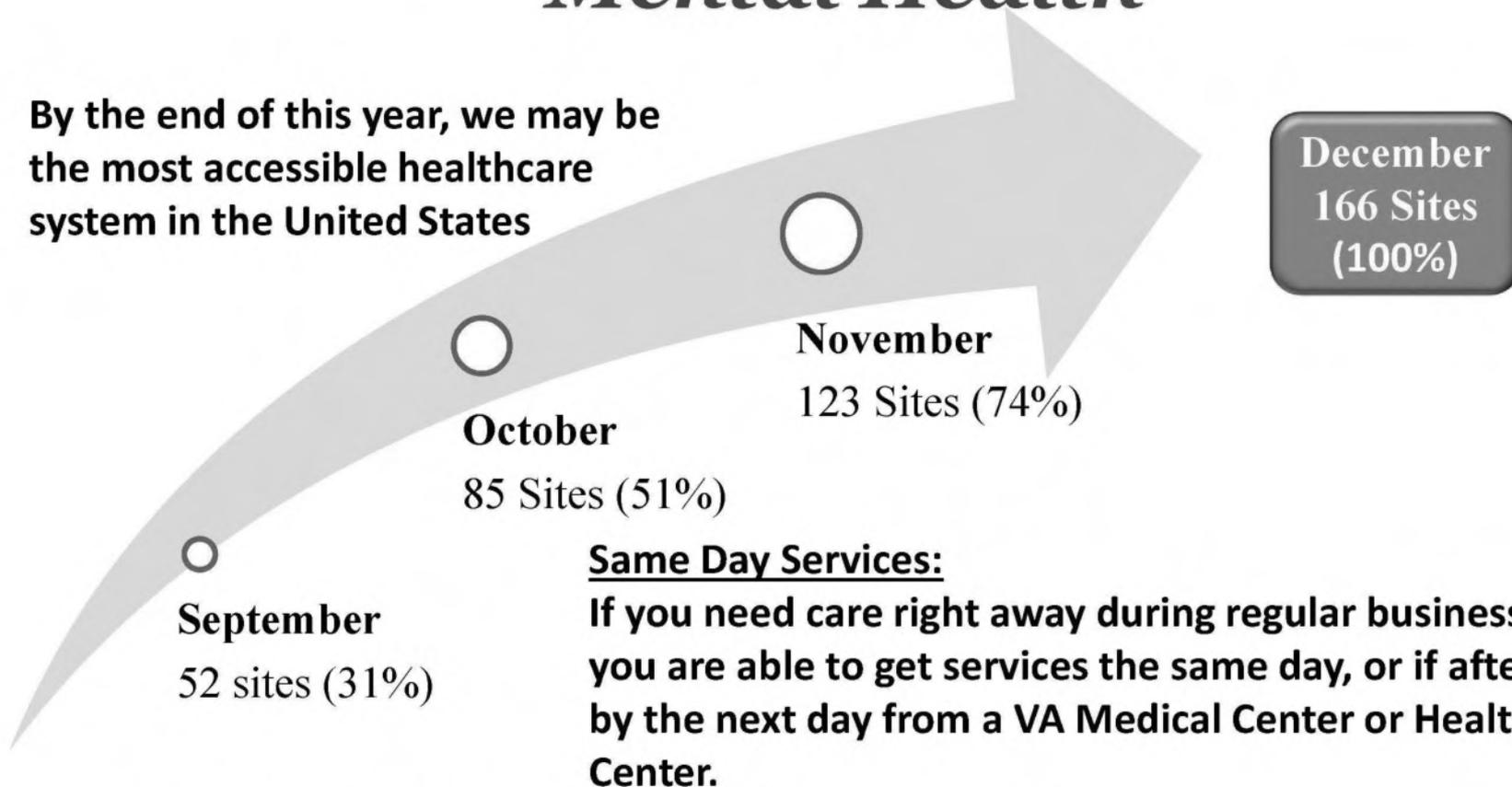
Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States



Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- For a medical emergency always call 911 or report to the emergency room closest to where you are located.

Priority 1: Access

Results that Impact Care

31

Reduced Categories
of Clinical Urgency In
Waiting for Care

2

57,000

STAT consults
in Nov. 2015

<600

in Nov. 2016

3.5 Million

Choice Act Authorizations, a **13% increase**

3.1 Million

More Appointments Scheduled in Last 2 Years

86 Facilities

Have **Same Day Access** in Primary Care & Mental Health. All 166 will by end of 2016.

96.62%

Appts. within 30 Days of Clinically Indicated Date

43.3%

STAT Consults
Same Day

88%

STAT Consults
within 7 Days

89%

Veterans
Satisfied with
Ability to Get
Appointment

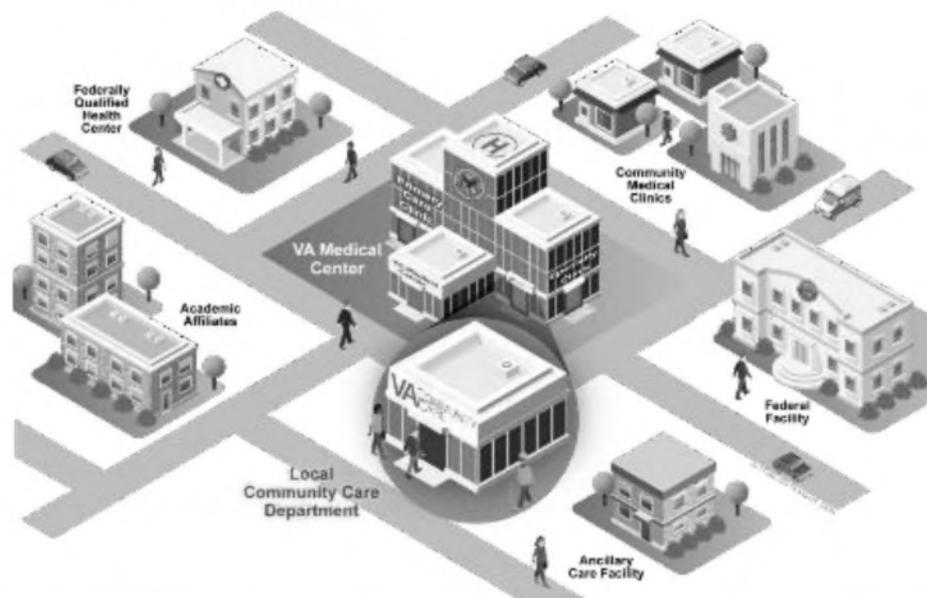
Priority 2: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
 - **85** of those replications have been completed **within 9 months**
 - **301** of those replication projects are **ongoing and on track**
 - **Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Priority 4: Employee Engagement

- VA Pulse - **94,339** unique users
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



Priority 5: Restoring Trust

**VETERANS
EXPERIENCE**



VE Measure		% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	% Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	% Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
BRAND	"I trust VA to fulfill our country's commitment to Veterans"	55%	59%	60%
EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
EASE	"It was easy to get the care or services I needed"	61%	65%	66%
EMOTION	"I felt like a valued customer"	63%	67%	68%

VHA Accomplishments in 2016

Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders

**Be there
for someone in your life.**

Connect fellow Veterans and Service members in crisis with support.

VeteransCrisisLine.net



U.S. Department
of Veterans Affairs



Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans.**
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010, **over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Public Health Issues

Hepatitis C Management

- In FY15 & 16, VA treated a total of **69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



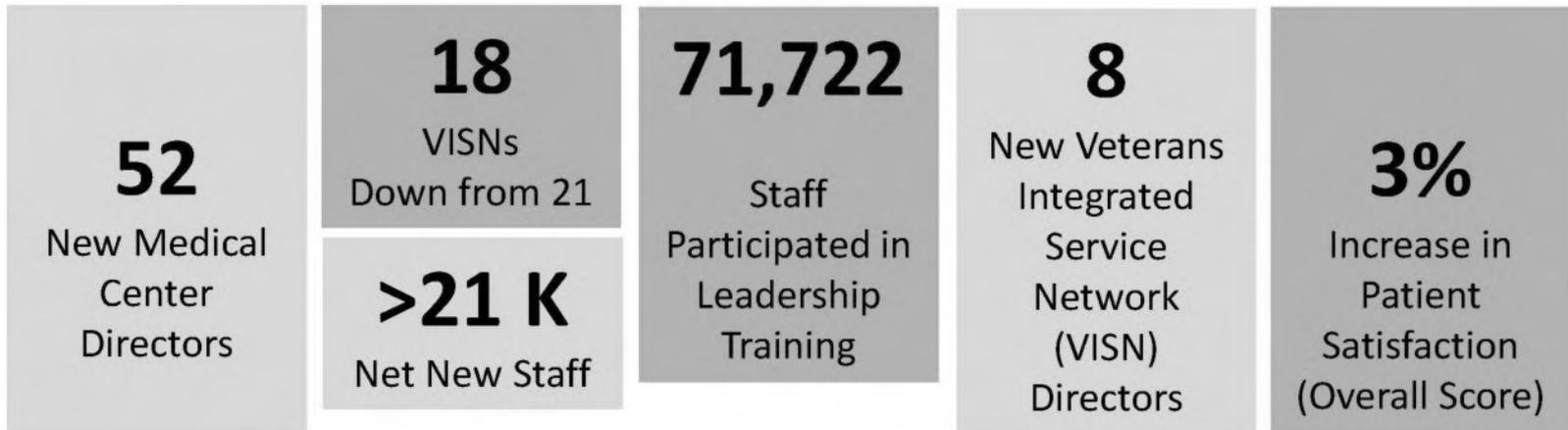
Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health



Building a Stronger Organization

- Recruited **new Principal Deputy Under Secretary for Health (PDUSH), Deputy Secretary for Health for Operations & Management (DUSHOM), 2 Assistant Deputy Under Secretary for Health (ADUSH positions), and all Deputy Under Secretary for Health (DUSH positions)**
- **8,490** new staff trained in **lean management**



Serving our Veterans and the Nation

Culture of Improvement

- 6th year – VA's pharmacy benefits ranked among best in class
- 24 million in cost avoidance through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board



82% of VAMCs with Improvement

SAIL Quality Measures in Past Year

Overall Quality FY15Q4-FY16Q3 ¹	FY16Q3 SAIL Quality Star Percentile Cut-Off					Total
	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17²	31²	55	28³	15³	146⁴

Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered “clinically significant”

Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

Future Direction, Priorities and Opportunities

S

Strengths

- Provides care for veterans no matter where they live
- Quality of Care
- Relationships with most academic and federal health organizations
- Primary Care/Behavioral Health Integration
- Centers of Excellence (e.g. Spinal Cord Injury, Ntl Center for PTSD)
- Addresses social determinants of Care Education of Medical Professionals
 - Research dedicated to improving veteran health

W

Weaknesses

- Capital infrastructure
- Choice program expiration
- Leadership vacancies
- New unfunded requirements
- Lack of flexibility in funding community care

Opportunities

- Public private partnerships
- Collaborate with academic, federal and community partners
- New technologies to improve care efficiency
- Plan to re-envision future care models
- Performing as an integrated enterprise

Threats

- Leadership changes
- Increased demand for care
- Choice program expiration
- Unfunded new mandates
- Retirements/loss of institutional knowledge

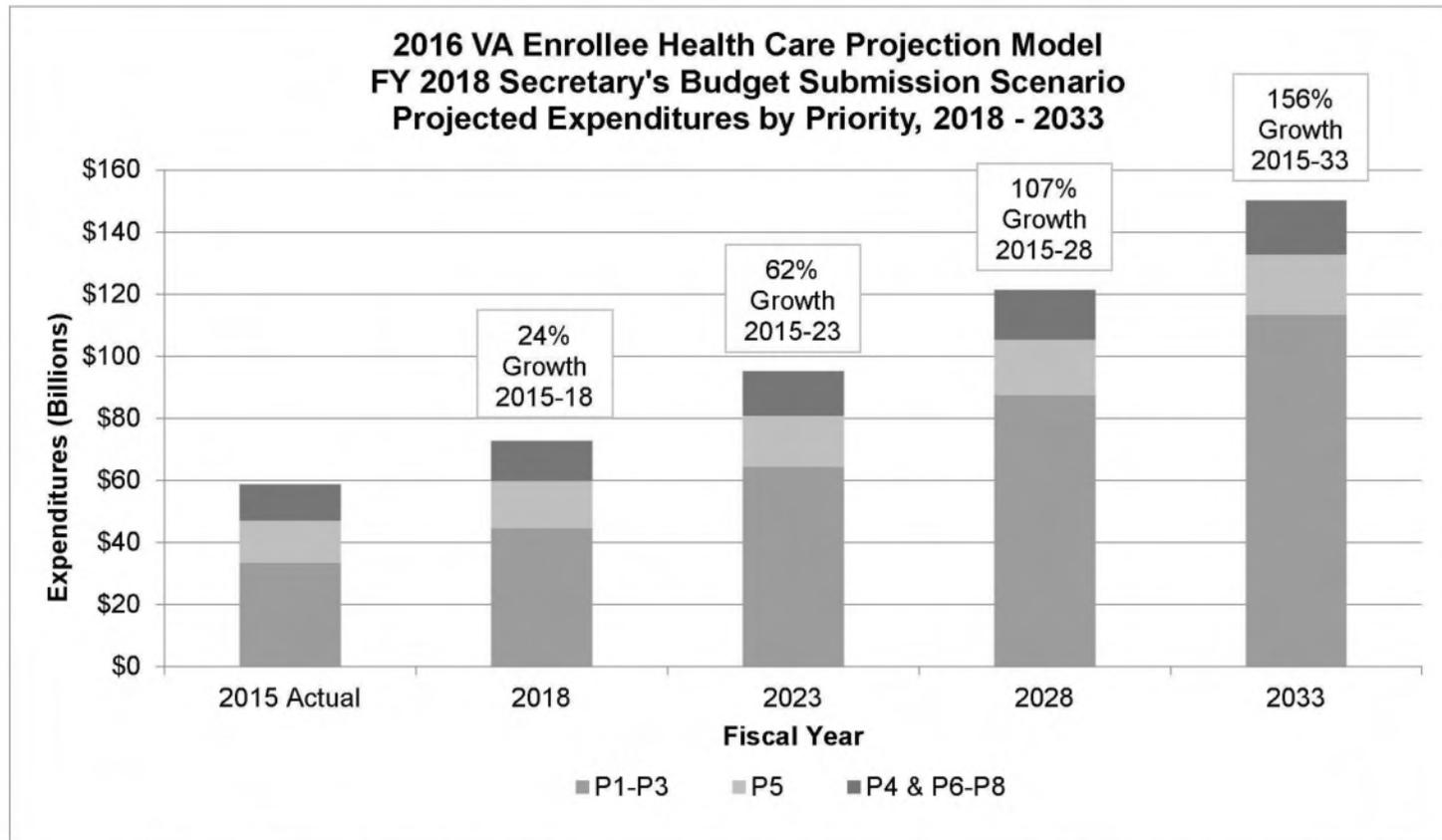
O

T

Increasing Demand

- VA completed nearly **5 million more appointments** in 2015 than in 2014 (FY 2016 data not yet available)
 - Almost **57 million appointments inside VA** and over 21 million in the community.
 - For Veterans that means **over 7 million additional hours of care**
- Veterans are aging and will need **more complex care and long term care** and support services
- Reliance on VA may grow as costs of other insurance and exchanges may increase
 - **Each 1 % increase in reliance is a cost of approximately \$1B**

VA's Resource Requirements *Projected to Grow Significantly Over Time*

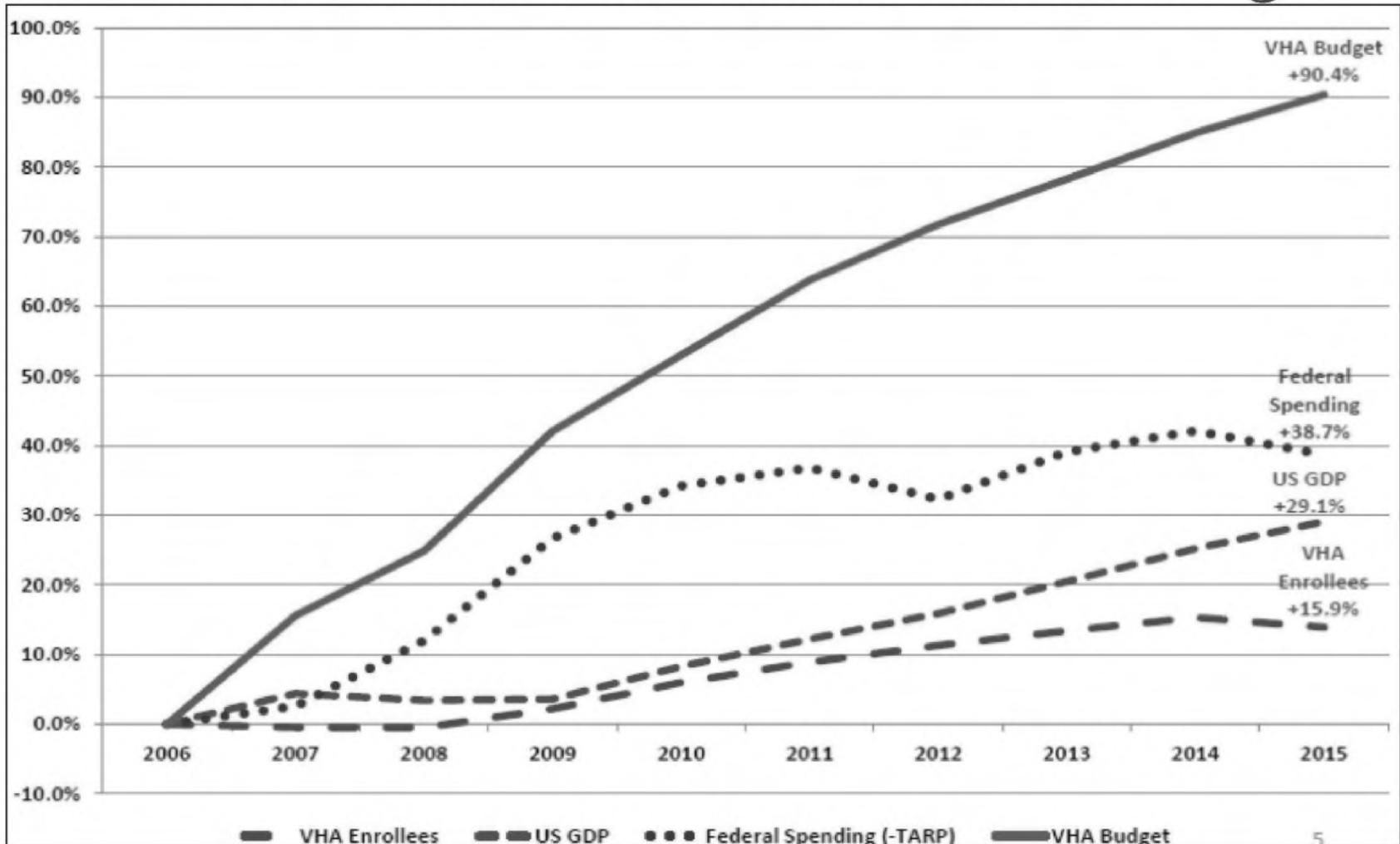


2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.



U.S. Department
of Veterans Affairs

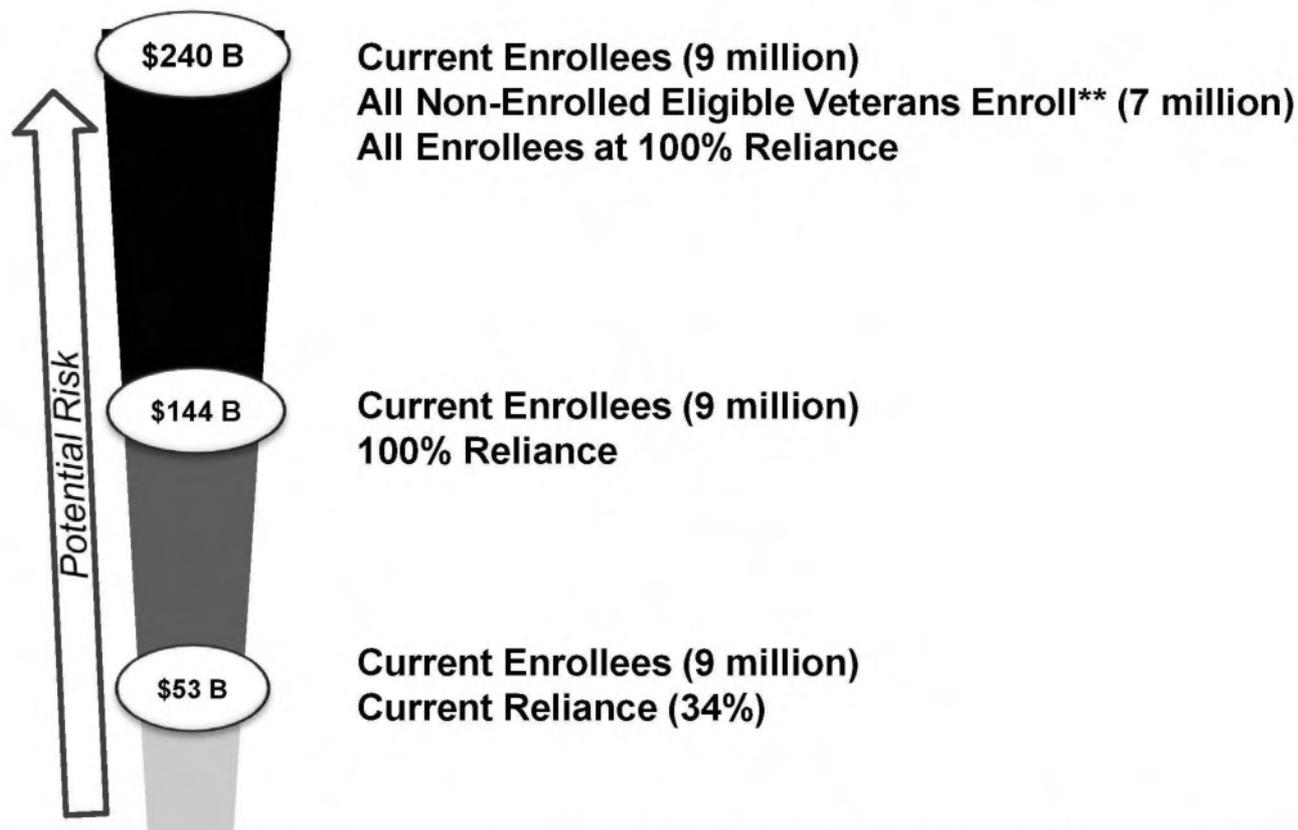
VA Medical Care Budget Challenge: Cumulative Growth 2006-2015



2018 Budget

- VHA's FY 2018 Advance Appropriation is **\$2.8 billion less** than the total funds available in FY 2017 – a 4% decrease
- Choice Program ends 8/7/17 (**\$3.3B per year**)
- Other risks that may impact future years -These items were not included in the FY 2017 enacted budget, which includes the FY 2018 Advance Appropriations
 - \$0.5-\$1.5 Billion – Staab Court Case (Emergency Care) May generate increased future utilization \$1-\$2 Billion
 - Presumptive Service Connection – Camp Lejeune Reservists
 - In Vitro Fertilization
 - Comprehensive Addiction and Recover Act (CARA)

Potential Changes in Veteran Enrollment & Reliance on VA Health Care*



*FY 2014 actual and projected expenditures from the 2015 VA Enrollee Health Care Projection Model for modeled services: excludes readjustment counseling, Caregivers, CHAMPVA and capital expenditures.

**Note, approximately 6 million of the 22 million Veterans in 2014 were not eligible to enroll in VA health care due to income.

VA



U.S. Department
of Veterans Affairs

Priorities for the Next Administration



Legislative Areas of Focus

- Choice Act Authority Expires 8/7/17
- Legislative fixes to “Care in the Community”
- Critical Pay for Medical Center Directors (1A) and VISN leaders
- The 80-hour pay period
- Special pay authority for VA health care senior managers
- Budget flexibility needed



Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans



A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students



Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/15/2016 9:22:57 PM
To: Jennifer Lee (b) (6) @gmail.com]
Subject: Re: Gender alteration - call w Sens Brown, Baldwin staff

Ok - i dont see how we could have handled differently

Sent from my iPhone

On Nov 15, 2016, at 4:14 PM, Jennifer Lee (b) (6) @gmail.com> wrote:

Hi David,

I just had a phone call with staffers from Senators Brown, Baldwin and SVAC minority. They were concerned about the letter that somehow became public - that the phrasing made it seem like we were passing the blame to them for not appropriating funds for the surgeries. 10P actually never had a chance to weigh in on this version of the letter? they asked for cost estimates

Message

From: Jennifer Lee [REDACTED]@gmail.com]
Sent: 11/15/2016 9:14:55 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Gender alteration - call w Sens Brown, Baldwin staff

Hi David,

I just had a phone call with staffers from Senators Brown, Baldwin and SVAC minority.

They were concerned about the letter that somehow became public - that the phrasing made it seem like we were passing the blame to them for not appropriating funds for the surgeries.

10P actually never had a chance to weigh in on this version of the letter?

they asked for cost estimates

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/27/2016 2:20:54 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Slides

Ok thanks

Sent from my iPhone

On Nov 27, 2016, at 8:20 AM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

please make sure you review this Fact Sheet too- this is a MUST USE!!

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, November 26, 2016 6:59 PM
To: Poonam Alaigh
Subject: Re: Slides

Im good

Sent from my iPhone

> On Nov 26, 2016, at 5:42 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

>

> Are you ok with them and are you able to open them - don't know why Vivieca just texted me that you can't open the slides and to send them again

>

> Sent from my iPhone

<MyVA Access Fact Sheet_110716_v9.docx>

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 11/27/2016 1:20:33 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Slides
Attachments: MyVA Access Fact Sheet 110716 v9.docx

please make sure you review this Fact Sheet too- this is a MUST USE!!

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, November 26, 2016 6:59 PM
To: Poonam Alaigh
Subject: Re: Slides

Im good

Sent from my iPhone

> On Nov 26, 2016, at 5:42 PM, Poonam Alaigh [REDACTED]@hotmail.com> wrote:

>

> Are you ok with them and are you able to open them - don't know why Vivieca just texted me that you can't open the slides and to send them again

>

> Sent from my iPhone

myVAaccess

Fact Sheet

Focus Areas	2014	2016
Leadership Commitment		
Access as a Priority	<ul style="list-style-type: none"> Inconsistent, fragmented and reactive approach towards improving access 	<ul style="list-style-type: none"> Access declared as the top strategic priority of VA Proactivity using a three pronged approach that sets the vision and roadmap for access improvement: Prong #1- MyVA Access Declaration, Prong #2- Implementation Guidebook and Prong #3- Systems Engineering and Deployment
Identification of Veterans with Immediate Need for Timely Care	<ul style="list-style-type: none"> Inability to identify Veterans with more immediate needs Variability in the timeliness of care for Veterans with more immediate needs 	<ul style="list-style-type: none"> Scheduling was simplified to identify Veterans with the most immediate needs In 2015 and 2016, two national stand down events were conducted to ensure Veterans with immediate needs received timely care VA's nationwide commitment to achieving same day services for all Veterans with care needed right away in primary care and mental health by the end of 2016
Accountability for Access	<ul style="list-style-type: none"> Lack of an integrated and accountable team to improve access in the organization 	<ul style="list-style-type: none"> ADUSH-level position created to lead newly created OVAC; solely focused on improving access to care in VHA
Care in the Community	<ul style="list-style-type: none"> Veterans had limited options for care in the community 	<ul style="list-style-type: none"> In addition to existing community programs, the Choice Program expanded to serve Veterans: <ul style="list-style-type: none"> The Choice provider network grew 85% over a year with over 350,000 providers and facilities Choice authorizations have quadrupled from 380,000 in FY15 to nearly 2 million in FY16
Programs and Practices		
Access Best Practices	<ul style="list-style-type: none"> Facilities had limited operational guidance regarding access improvement Facilities were unaware of best practices in existence at other VAs 	<ul style="list-style-type: none"> MyVA Access Implementation Guidebook with 23 highly feasible/highly impactful solutions that help facilities achieve enhanced access The VA Diffusion of Excellence Council also developed 11 access best practices for facility use
Seamless Care	<ul style="list-style-type: none"> Veterans found it challenging to receive care from a VAMC different from their primary VA as their medical information was not readily available and staff at the receiving facility were unprepared for accepting such Veterans for care 	<ul style="list-style-type: none"> Veterans can seamlessly receive medical care and any information relevant to their care from any VA medical facility
Direct Scheduling without Primary Care Referral	<ul style="list-style-type: none"> Referrals were required from primary care for Veterans to receive basic healthcare services 	<ul style="list-style-type: none"> Veterans can direct schedule appointments with audiology and optometry clinics with a plan for additional specialties to be added in 2017

myVAaccess

Fact Sheet

Convenient Self Scheduling (VAR)	<ul style="list-style-type: none"> Inability for Veterans to schedule their own medical appointments 	<ul style="list-style-type: none"> Completed successful pilots for VAR roll out VAR will allow patients to self-schedule appointments using the application and is scheduled for general roll from Dec 2016 to Feb 2017
Expanding Telehealth Opportunity	<ul style="list-style-type: none"> Telehealth options locally-oriented within healthcare systems or networks 	<ul style="list-style-type: none"> Establishing national, networked telehealth programs to maximize usage: <ul style="list-style-type: none"> Over 1.5 million episodes of care reaching about 700K Veterans Four telemental health hubs launched during 2016, five more telemental health hubs are presently being stood up
Tele-Video Care	<ul style="list-style-type: none"> Lack of convenient, innovative video telehealth care for Veteran and provider to interact 	<ul style="list-style-type: none"> Clinical video telehealth program with a “secured Skype” like modality using smart phones/tablets has been developed and will be rolled out in local facilities in 2017
Communication and Training		
Field Focused Communication	<ul style="list-style-type: none"> Incomplete field input on access initiatives Disjointed access communication with conflicting messages to local facilities 	<ul style="list-style-type: none"> Established a bi-directional communication with field through working groups, educational sessions, standing meetings, leadership engagement, national meetings and forums like MyVA Access Community of Practice Calls MyVA Access has an integrated communications plan guided by field-led IPT that developed a Veterans Awareness Campaign with templates and tools for same day services at VA
MSA Training	<ul style="list-style-type: none"> Lack of standardized, coordinated training for MSAs 	<ul style="list-style-type: none"> Standardized MSA training established to include key topics such as customer service, Veteran experience and VSE, being rolled out by Dec 2016
Streamlined Consult Scheduling	<ul style="list-style-type: none"> Thirty-one different ways to categorize a consult for scheduling 	<ul style="list-style-type: none"> Consult scheduling has been streamlined to two options: routine and urgent
HR and Capital Investments		
Group Practice Managers	<ul style="list-style-type: none"> Disjointed clinical administrative operations to support access at VA Medical Centers No GPM role or function 	<ul style="list-style-type: none"> GPMs are newly established roles that manage operations for all VA Medical facilities and conduct daily mini data-driven huddles for access improvement 135 GPMs have been hired nationwide

myVAaccess

Fact Sheet

Human Capital and Space	<ul style="list-style-type: none"> Human capital and space for patient care activities were routinely cited as challenges to access. 	<ul style="list-style-type: none"> Hired approximately 95,000 employees, a 9.2% increase. Of these, over 7000 were physicians and over 17,000 nurses, increases of 11.2% and 11.9% respectively. Activated 2.6 million square feet for patient care and supporting activities Increased direct patient care by 11%, approximately 7.4 million additional patient care hours
Performance Measures and Outcomes		
Healthcare Dashboard	<ul style="list-style-type: none"> Lack of standardized access metrics for use at local facilities 	<ul style="list-style-type: none"> Newly established healthcare dashboard that is used by national leadership and local facilities to manage access in real time including during daily mini-data driven huddles
Public Facing Data	<ul style="list-style-type: none"> Public facing data did not provide meaningful signals of VA access improvements in Veteran satisfaction 	<ul style="list-style-type: none"> Early 2017, VA website will transparently report on meaningful signals that indicate VA progress in patient satisfaction with access and same day services capability
Veteran Satisfaction	<ul style="list-style-type: none"> Lack of real-time data to assess Veteran satisfaction 	<ul style="list-style-type: none"> In FY16 89.4% of 2.6 M Veterans indicated they were completely satisfied or satisfied with access to care at VA through VetLink kiosks
Wait Times	<ul style="list-style-type: none"> Wait times were 19.1 days from create date for all new patients 	<ul style="list-style-type: none"> Wait times were 17.2 days from create date for all new patients, which is a decrease of 1.9 days
Veterans with Immediate Needs	<ul style="list-style-type: none"> 50.4% of referrals for new patients with urgent needs were completed within 7 days There were around 57K stat consults in November 2015 waiting longer than 30 days for care 	<ul style="list-style-type: none"> In FY16, 61.0% of referrals for new patients with more immediate needs were completed within 7 days, an increase of 10.6% from FY14. Around 500 stat consults are currently waiting longer than 30 days for care
Total Appointments and Users	<ul style="list-style-type: none"> In FY14, there were 5.7M unique users and 70.8M total appointments within VA and in the community 	<ul style="list-style-type: none"> In FY16, there were 5.8M unique users and 74.2M total appointments, an increase of approximately 76,000 users and 3.4M appointments

SUPPLEMENTAL MATERIAL

Acronyms

ADUSH	Assistant Deputy Under Secretary of Health
CoP	Community of Practice
GPM	Group Practice Manager
HR	Human Resources
IPT	Integrated Project Team
MSA	Medical Scheduling Assistant
OVAC	Office of Veterans' Access to Care
VA	Department of Veterans Affairs
VAR	Veterans Appointment Request
VSE	VistA Scheduling Enhancement

*my***VA**access
Declaration

1. Provide timely care, including same-day services in Primary Care, as needed
2. Provide timely Mental Health care, including same day services, as needed
3. Provide Veterans medically necessary care from another VA Medical Center, while away from their primary facility
4. Respond to routine clinical inquiries within 2 business days
5. Offer appointments and other follow-up options upon leaving clinic
6. Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances
7. Integrate community providers as appropriate to enhance access
8. Offer Veterans extended clinic hours, and/or virtual care options, such as Telehealth, when appropriate
9. Transparently report access to care data to Veterans and to the public

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/26/2016 11:59:44 PM
To: Poonam Alaigh [REDACTED]@hotmail.com]
Subject: Re: Slides

Im good

Sent from my iPhone

> On Nov 26, 2016, at 5:42 PM, Poonam Alaigh [REDACTED]@hotmail.com> wrote:

>

> Are you ok with them and are you able to open them - don't know why Vivieca just texted me that you can't open the slides and to send them again

>

> Sent from my iPhone

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 11/26/2016 10:42:55 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Slides

Are you ok with them and are you able to open them - don't know why Vivieca just texted me that you can't open the slides and to send them again

Sent from my iPhone

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 2:33:11 AM
To: (b) (6) @bsgtv.com
CC: (b) (6) (b) (6) @gmail.com]
Subject: Re: Reference for Josefina Jervis

I am glad to do but i am not able to do this until next week- my office will find 10 minutes sometime next week

Sent from my iPhone

On Nov 29, 2016, at 4:26 PM, (b) (6) (b) (6) @bsgtv.com> wrote:

Dr. Shulkin,

(b) (6) listed you as a reference for a position (b) (6) is pursuing with Ponce Health Sciences University and University Ventures. I'd like to coordinate a brief call with the lead recruiter, (b) (6) (b) (6) is on the West Coast and has the following availability this week: Wednesday, 11/30, at 9:30am, 10am, 10:30am and 11:30am PT; Thursday, 12/1, at 9:30am or 10am PT; and Friday, 12/2, at 9am PT. If one of these options works with your schedule please confirm a date/time and provide the best number for (b) (6) to call. This call should take about 15-20 minutes.

Thank you for your help.

Kind Regards,

(b) (6)

(b) (6)
Recruiting and Research Assistant, Education Team
Email (b) (6) @bsgtv.com

<image001.png>

A member of the Tinzon Group of Global Executive Search Firms

BSG TEAM VENTURES, LLC | web: www.bsgtv.com

224 Clarendon Street (corner of Newbury), Suite 41 | Boston, MA 02116

101 Mission Street (corner of Spear), Suite 700 | San Francisco, CA 94105

1140 Avenue of the Americas, 9th Floor | New York, NY 10036

205 - 207 High Street | Cottenham | Cambridge, UK CB24 8RX

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/12/2016 3:03:13 PM
To: (b) (6)@hotmail.com
Subject: Re:

Thanks for the note- I agree

Monday night sounds good

yes plan on Dallas- we have to make the most of our time

-----Original Message-----

From: Poonam Alaigh (b) (6)@hotmail.com
To: David shulkin <Drshulkin@aol.com>
Sent: Sat, Nov 12, 2016 8:20 am
Subject: Re: Fwd:

Remember what you told me about advice you got- "if you want loyalty in DC, get a dog" - not surprising though never easy to digest. We are really fortunate that at least our relationship is based on principles that are so basic, simple but rare - looking out for one another, respect, genuineness and sincerity.

Great post on the Bush Center- should I make arrangements to be there then, specifically have to change my Friday night plans and my call on Saturday- not a problem but wanted to confirm before I did it.

I absolutely loved the pictures you sent last night- most importantly seeing (b) (6) and (b) (6) big bright smile that showed in (b) (6) eyes. So glad you all had what appears to be an awesome time with the family- (b) (6) specifically sacrifices and bears so much to make you who you are- (b) (6) needs to be treated like (b) (6) every step of the way.

I will let you know what I will do about coming into DC - probably Monday morning since we had plans Sunday afternoon that I wont have to curb that way.

Do you want to have dinner Monday night and we can catch up on misc stuff including that software startup tablet program which we were going to discuss on the train and I will then bring with me. I also want to hear about other things including tomorrow's Mike meeting.

Sent from my iPad

On Nov 11, 2016, at 9:35 PM, David shulkin <Drshulkin@aol.com> wrote:

So much for loyalty

Looks like bagger has been replaced

<http://www.bushcenter.org/publications/articles/2016/11/dave-shulkin-on-the-invisible-wounds-of-war.html>

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: November 11, 2016 at 9:33:51 PM EST
To: 'Dr Shulkin' <drshulkin@aol.com>

<https://www.washingtonpost.com/news/powerpost/wp/2016/11/11/pence-to-lead-trump-transition-effort/>

Message

From: Poonam Alai [b] (6) [redacted]@hotmail.com]
Sent: 11/12/2016 1:20:06 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd:

Remember what you told me about advice you got- "if you want loyalty in DC, get a dog" - not surprising though never easy to digest. We are really fortunate that at least our relationship is based on principles that are so basic, simple but rare - looking out for one another, respect, genuineness and sincerity.

Great post on the Bush Center- should I make arrangements to be there then, specifically have to change my Friday night plans and my call on Saturday- not a problem but wanted to confirm before I did it.

I absolutely loved the pictures you sent last night- most importantly seeing [b] (6) [redacted] and [b] [redacted] big bright smile that showed in [b] [redacted] eyes. So glad you all had what appears to be an awesome time with the family- [b] (6) [redacted] specifically sacrifices and bears so much to make you who you are- she needs to be treated like a [b] (6) [redacted] every step of the way.

I will let you know what I will do about coming into DC - probably Monday morning since we had plans Sunday afternoon that I wont have to curb that way.

Do you want to have dinner Monday night and we can catch up on misc stuff including that software startup tablet program which we were going to discuss on the train and I will then bring with me. I also want to hear about other things including tomorrow's Mike meeting.

Sent from my iPad

On Nov 11, 2016, at 9:35 PM, David shulkin <Drshulkin@aol.com> wrote:

So much for loyalty

Looks like bagger has been replaced

<http://www.bushcenter.org/publications/articles/2016/11/dave-shulkin-on-the-invisible-wounds-of-war.html>

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: November 11, 2016 at 9:33:51 PM EST
To: 'Dr Shulkin' <drshulkin@aol.com>

<https://www.washingtonpost.com/news/powerpost/wp/2016/11/11/pence-to-lead-trump-transition-effort/>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/12/2016 2:35:40 AM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Fwd:

So much for loyalty

Looks like bagger has been replaced

<http://www.bushcenter.org/publications/articles/2016/11/dave-shulkin-on-the-invisible-wounds-of-war.html>

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: November 11, 2016 at 9:33:51 PM EST
To: 'Dr Shulkin' <drshulkin@aol.com>

<https://www.washingtonpost.com/news/powerpost/wp/2016/11/11/pence-to-lead-trump-transition-effort/>

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/26/2016 4:47:28 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Try this

It worked! You are a miracle worker!

Sent from my iPad

On Nov 26, 2016, at 11:19 AM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

these versions are really old from 1997- 2004- if this doesnt work, then we will have to work on it on monday- good thing is that it is all here- all you have to do it is customize it to your needs

<TT- version 8.pot>

<TT- version 8.ppt>

Message

From: Poonam Alaigh [redacted@hotmail.com]
Sent: 11/26/2016 4:19:34 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Try this
Attachments: TT- version 8.pot; TT- version 8.ppt

these versions are really old from 1997- 2004- if this doesnt work, then we will have to work on it on monday- good thing is that it is all here- all you have to do it is customize it to your needs



VA

U.S. Department
of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
 - Organization, Budget and FTEs
 - Our Mission and Who We Serve
 - Assessment of VHA's Situation
 - Priorities
 - Performance
 - Accomplishments in FY 2016
 - Future Direction, Priorities and Opportunities for VHA



Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

VA



U.S. Department
of Veterans Affairs

Organization, Budget and FTEs



Organizational Leadership

Veterans Health Administration | Leadership

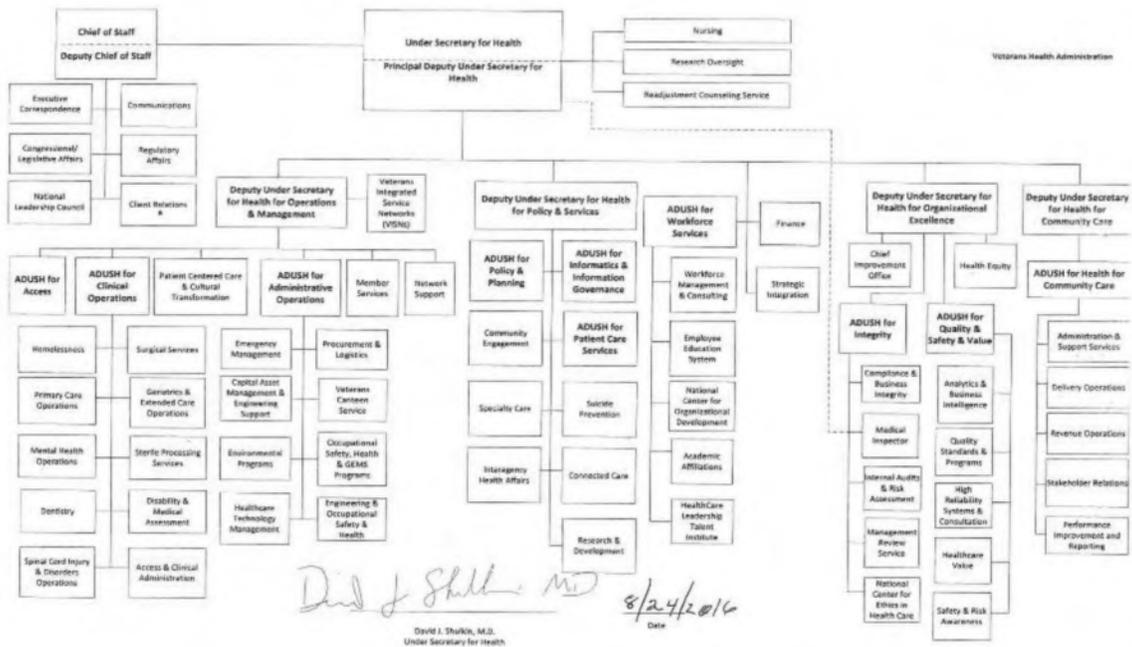
As of November 14, 2016



VA U.S. Department of Veterans Affairs



Organization Chart



Draft / Pre-decisional / For Internal VA Use Only



Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
\$72,835,537	\$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

VA



U.S. Department
of Veterans Affairs

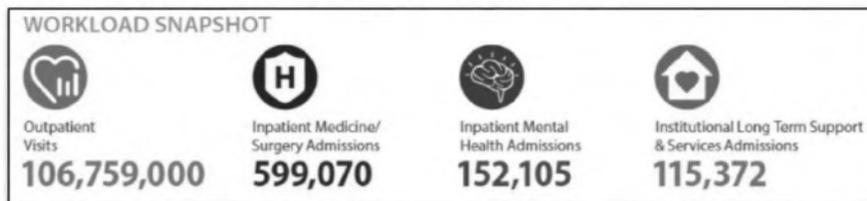
How We Are Different: Our Mission and Who We Serve



The Largest Healthcare System in the United States

- 1,234 health care facilities
 - 168 VA Medical Centers
 - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)
- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



VA



U.S. Department
of Veterans Affairs

Annual Financial Report source file for graphic

Who We Serve

- Veterans who rely most on the VA
 - Veterans with lower income
 - Veterans living in rural areas
 - Veterans without other access to health insurance coverage
 - Veterans with poorer self-reported health status
 - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

VHA's Four Missions

Overall Objective:

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Care Delivery	Develop, maintain, and operate a national health care delivery system for eligible Veterans.
Education	Administer a program of education and training for health care personnel.
Research	Conduct health care research benefitting Veterans and public
Emergency Response	Provide contingency support for Department of Defense (DOD) and Department of Health and Human Services (HHS) during times of war or national emergency

Our mission extends beyond healthcare for Veterans

VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

VA



U.S. Department
of Veterans Affairs

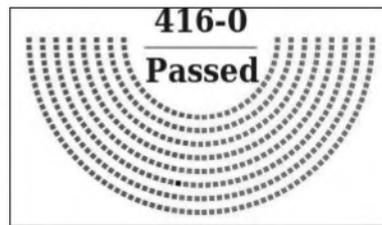
VA Healthcare Costs Not Found in the Private Sector

\$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	\$853	\$888	\$924
Camp Lejeune	\$10	\$24	\$21
Caregivers	\$454	\$623	\$725
CHAMPVA, Spina Bifida, FMP, CWVV	\$1,547	\$1,817	\$1,920
Comprehensive Emergency Medical Program	\$147	\$135	\$139
Dental Care	\$1,005	\$1,035	\$1,433
Health Professions Educational Assistance programs	\$37	\$56	\$70
Homeless Programs	\$1,507	\$1,477	\$1,591
Income Verification Match	\$17	\$19	\$19
Long Term Care	\$7,702	\$8,223	\$8,588
Readjustment Counseling	\$221	\$258	\$244
Rural Health Outreach Initiatives	\$219	\$270	\$250
Sharing Agreements - Services Provided by VA	\$157	\$157	\$166
Subtotal	\$13,875	\$14,980	\$16,090
Hepatitis C (assume 50% greater benefit)	\$406.1	\$500.0	\$500.0
Mental Health (assume 50% greater benefit)	\$2,283.9	\$2,494.9	\$2,610.6
Prosthetics (assume 50% greater benefit)	\$909.0	\$950.3	\$1,215.2
Subtotal	\$3,599.0	\$3,945.2	\$4,325.9
Total	\$17,473.9	\$18,924.9	\$20,415.8

Educational
Employment Services

20 Years of Increasing Demand for Services

- 1996 “Veterans Eligibility Reform Act”
- Conflicts in Afghanistan and Iraq continued
 - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 “The Veterans Access, Choice and Accountability Act”



- Enactment of Public Law 104-262, “Veterans Eligibility Reform Act” in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality is equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

VA



U.S. Department
of Veterans Affairs

Impact of VHA Research

VA



U.S. Department
of Veterans Affairs

VHA Priorities



USH 5 Priorities for Strategic Action

<p>Access</p> <p>We will provide timely access to Veterans as determined by their clinical needs.</p> <p>PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs</p>	<p>Employee Engagement</p> <p>We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.</p> <p>PSA: We will work to allow staff to have greater input into their work environment.</p>	
<p>High Performance Network</p> <p>We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.</p> <p>PSA: We will build a high performance network of care to best serve Veterans.</p>	<p>Best Practices</p> <p>We will use best clinical practices. We also seek best practices in research, education, and management.</p> <p>PSA: We seek to identify and disseminate best practices throughout VA.</p>	<p>Veterans First: Trust in VA Care</p> <p>We will be there for our Veterans when they need us.</p> <p>PSA: We will share our results on the quality and timeliness of how we care for Veterans.</p>

Priority 1: Access Transformative Changes



MyVA Access
Declaration

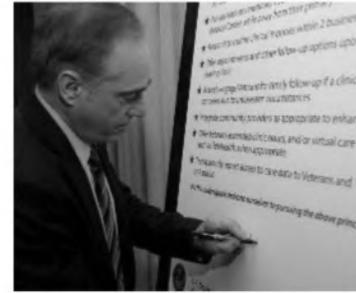
Prong 1

Prong 2

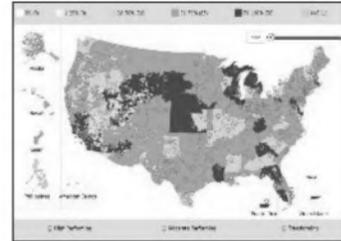
Access
Improvement
Solutions

National
Deployment
Strategy

Prong 3



*Dr. David Shulkin signing the MyVA
Declaration Statement on 4/7/2016*



19

VA



U.S. Department
of Veterans Affairs

Transformative changes heading

Prong

Guidebook

Map

Same day Services for urgent needs

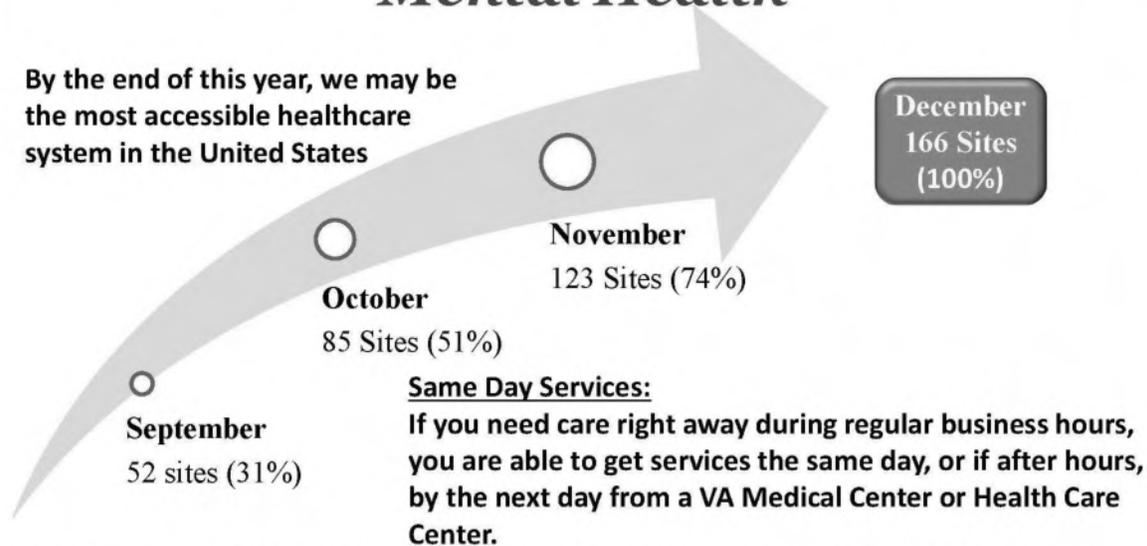
Path to SDA

Third slide is Results and impact that improve access

Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States



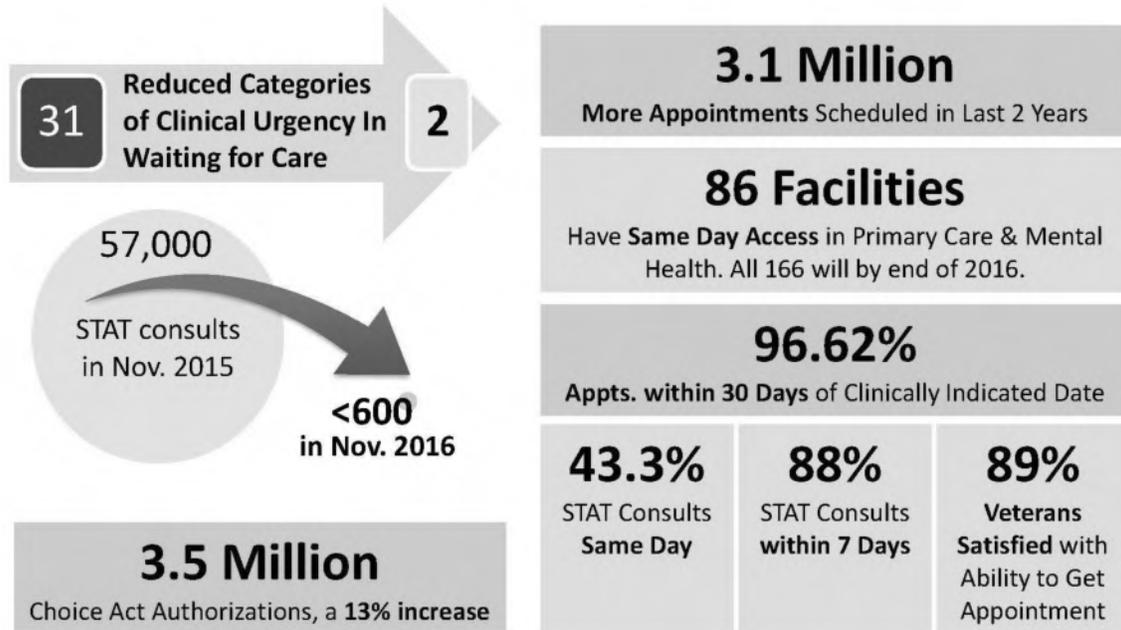
Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- For a medical emergency always call 911 or report to the emergency room closest to where you are located.

Priority 1: Access

Results that Impact Care



Draft / Pre-decisional / For Internal VA Use Only

21

VA



U.S. Department of Veterans Affairs

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)

57,000 stat consults in Nov 2015 to <600 in November 2016

3.1 Million more appointments scheduled in the last 2 years

86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016

89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)

In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date

43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)

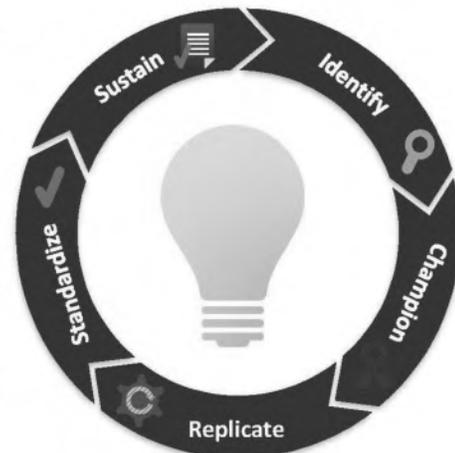
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16

Expanded scheduled hours on weekends and evenings, productivity, people, and space

More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

Priority 2: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
 - **85** of those replications have been completed **within 9 months**
 - **301** of those replication projects are **ongoing and on track**
 - **Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only

23

VA



U.S. Department
of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:

1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	% Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	% Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
		VETERANS EXPERIENCE <ul style="list-style-type: none"> BRAND EFFECTIVE EASE EMOTION 		“I trust VA to fulfill our country’s commitment to Veterans”	55%
	“I got the care or service I needed”		72%	74%	75%
	“It was easy to get the care or services I needed”		61%	65%	66%
	“I felt like a valued customer”		63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

VHA Accomplishments in 2016



Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders

**Be there
for someone in your life.**

Connect fellow Veterans and Service members in crisis with support.

VeteransCrisisLine.net



U.S. Department
of Veterans Affairs



Veterans
Crisis Line
1-800-273-8255 PRESS 6

Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans.**
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010, **over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations:
http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

Public Health Issues

Hepatitis C Management

- In FY15 & 16, VA treated a total of **69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health



Building a Stronger Organization

- Recruited **new Principal Deputy Under Secretary for Health (PDUSH), Deputy Secretary for Health for Operations & Management (DUSHOM), 2 Assistant Deputy Under Secretary for Health (ADUSH positions), and all Deputy Under Secretary for Health (DUSH positions)**
- **8,490** new staff trained in **lean management**



5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

Serving our Veterans and the Nation

Culture of Improvement

- 6th year – VA's pharmacy benefits ranked among best in class
- 24 million in cost avoidance through our supply chain efforts
- An Integrated operations center to proactively monitor and identify issues in quality or access
- 23,000 pounds of used medications returned and destroyed this year

Service to the Nation

- 9,860 research publications in 2016
- Added 547.4 graduate medical education positions
- Responded and deployed to 6 national emergencies



VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:

Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

82% of VAMCs with Improvement *SAIL Quality Measures in Past Year*

FY16Q3 SAIL Quality Star Percentile Cut-Off						
Overall Quality FY15Q4-FY16Q3 ¹	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17²	31²	55	28³	15³	146⁴

Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

Studies showing better outcomes
JAMA

Comparing VA Care to Private Sector

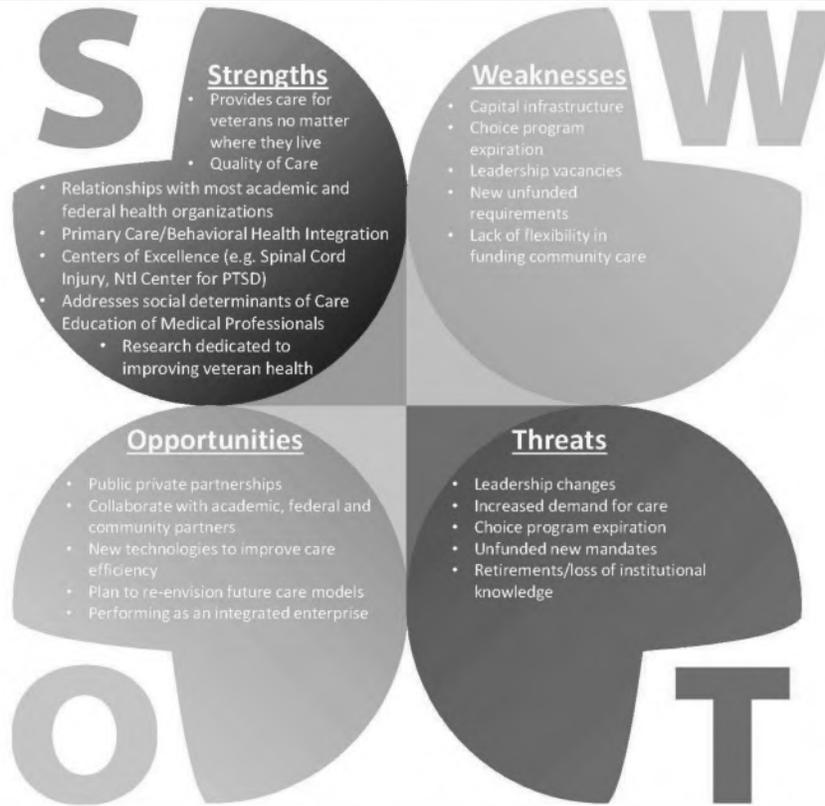
- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment



More data in press release: <http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778>

Future Direction, Priorities and Opportunities





Increasing Demand

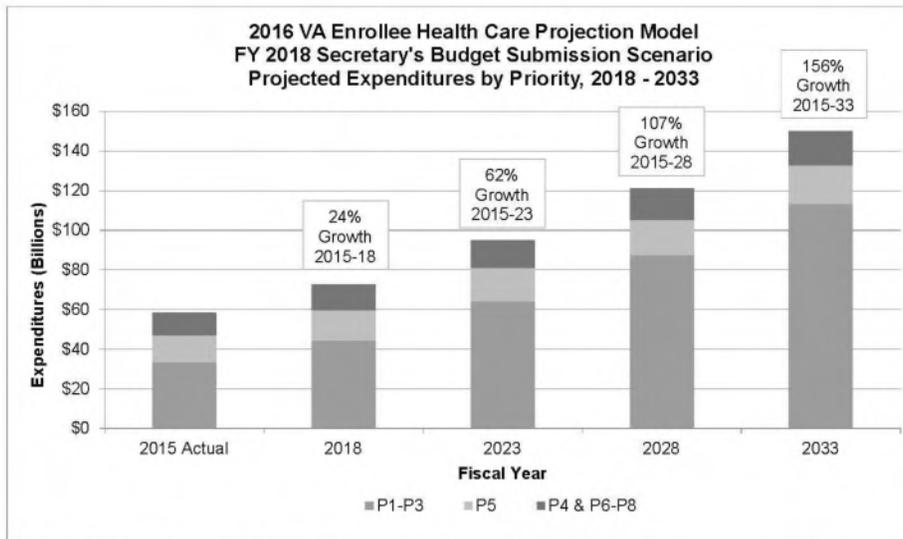
- VA completed nearly **5 million more appointments** in 2015 than in 2014 (FY 2016 data not yet available)
 - Almost **57 million appointments inside VA** and over 21 million in the community.
 - For Veterans that means **over 7 million additional hours** of care
- Veterans are aging and will need **more complex care and long term care** and support services
- Reliance on VA may grow as costs of other insurance and exchanges may increase
 - **Each 1 % increase in reliance is a cost of approximately \$1B**

3rd bullet notes:

In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

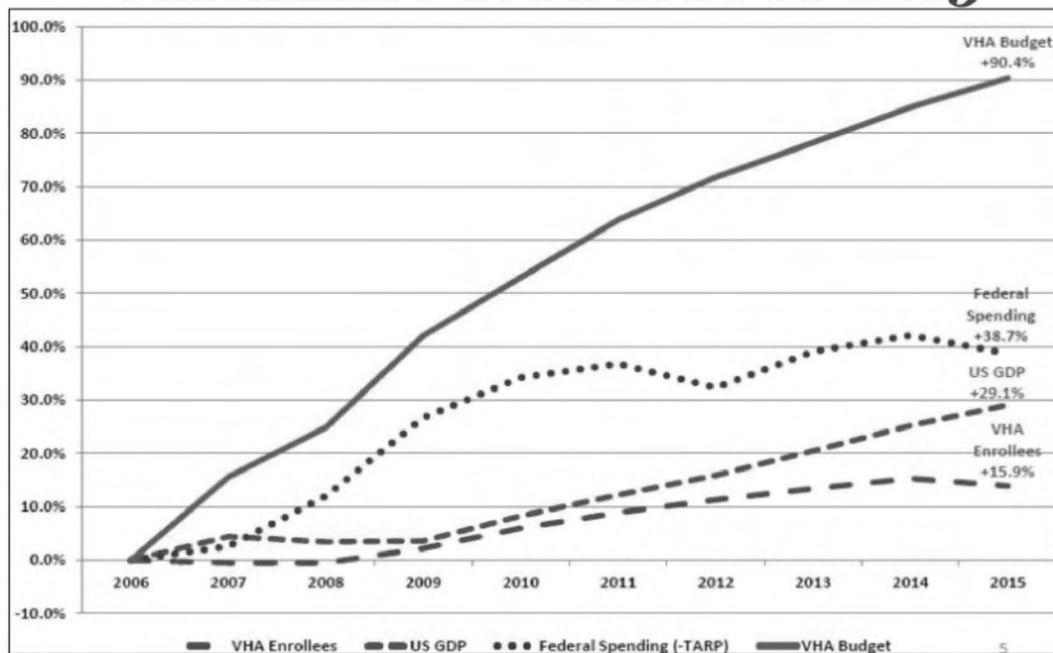
Latriece mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

VA's Resource Requirements Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

VA Medical Care Budget Challenge: Cumulative Growth 2006-2015



2018 Budget

- VHA's FY 2018 Advance Appropriation is **\$2.8 billion less** than the total funds available in FY 2017 – a 4% decrease
- Choice Program ends 8/7/17 (**\$3.3B per year**)
- Other risks that may impact future years -These items were not included in the FY 2017 enacted budget, which includes the FY 2018 Advance Appropriations
 - \$0.5-\$1.5 Billion – Staab Court Case (Emergency Care) May generate increased future utilization \$1-\$2 Billion
 - Presumptive Service Connection – Camp Lejeune Reservists
 - In Vitro Fertilization
 - Comprehensive Addiction and Recover Act (CARA)

Bullet 3: Estimated budget numbers:

IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds

Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate

CARA = \$153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:

adult leukemia

aplastic anemia and other myelodysplastic syndromes

bladder cancer

kidney cancer

liver cancer

multiple myeloma

non-Hodgkin's lymphoma

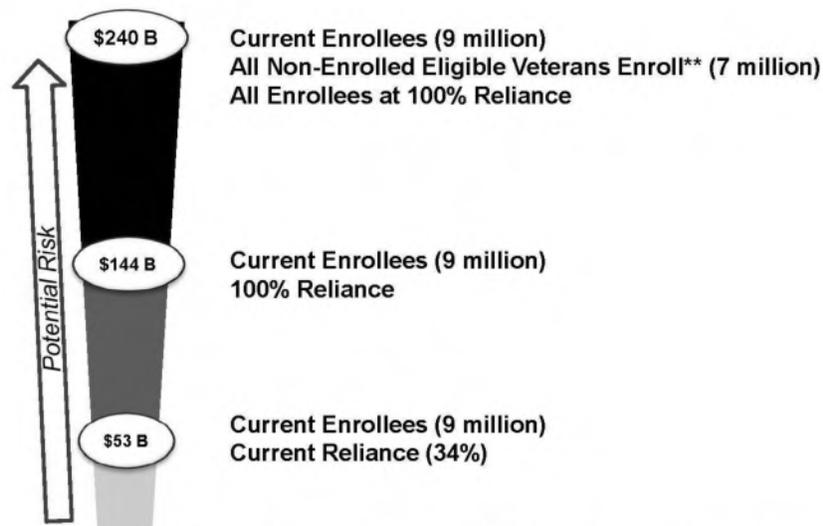
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

Potential Changes in Veteran Enrollment & Reliance on VA Health Care*



*FY 2014 actual and projected expenditures from the 2015 VA Enrollee Health Care Projection Model for modeled services: excludes readjustment counseling, Caregivers, CHAMPVA and capital expenditures.

**Note, approximately 6 million of the 22 million Veterans in 2014 were not eligible to enroll in VA health care due to income.



In 2014, costs for modeled services for 9 million enrollees at 34% reliance was \$53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been \$144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been \$240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

Priorities for the Next Administration



Continuity of Leadership during a Crisis

Leadership vacancies and succession planning

Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust

Direction of the Commission on Care Recommendations

Supporting VHA's Course for a Future Vision

Legislative Areas of Focus

- Choice Act Authority Expires 8/7/17
- Legislative fixes to “Care in the Community”
- Critical Pay for Medical Center Directors (1A) and VISN leaders
- The 80-hour pay period
- Special pay authority for VA health care senior managers
- Budget flexibility needed

3RD BULLET:

The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

Attached for reference is the signed/dated letter from OPM regarding critical pay.

Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students





VA

U.S. Department
of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
 - Organization, Budget and FTEs
 - Our Mission and Who We Serve
 - Assessment of VHA's Situation
 - Priorities
 - Performance
 - Accomplishments in FY 2016
 - Future Direction, Priorities and Opportunities for VHA

Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

VA



U.S. Department
of Veterans Affairs

Organization, Budget and FTEs



Organizational Leadership

Veterans Health Administration | Leadership

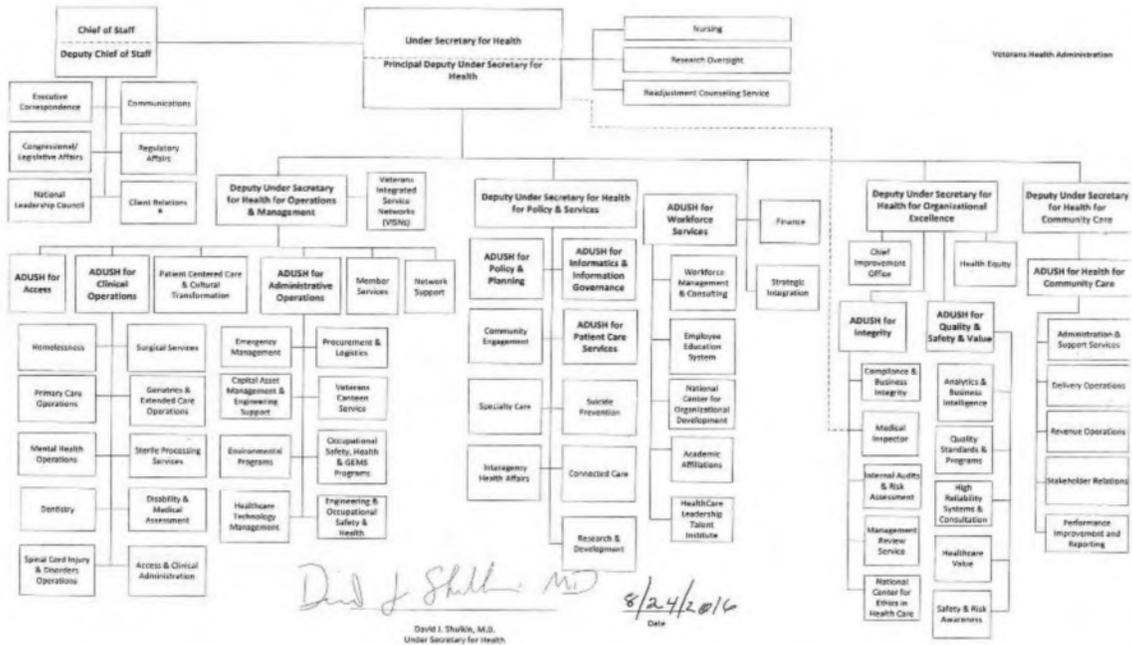
As of November 14, 2016



VA | U.S. Department of Veterans Affairs



Organization Chart



Draft / Pre-decisional / For Internal VA Use Only



U.S. Department of Veterans Affairs

Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
\$72,835,537	\$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

VA



U.S. Department
of Veterans Affairs

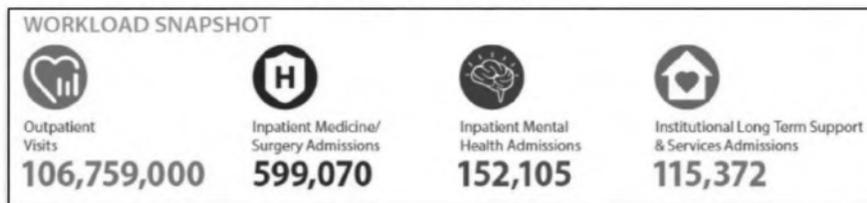
How We Are Different: Our Mission and Who We Serve



The Largest Healthcare System in the United States

- 1,234 health care facilities
 - 168 VA Medical Centers
 - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)
- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



VA



U.S. Department
of Veterans Affairs

Annual Financial Report source file for graphic

Who We Serve

- Veterans who rely most on the VA
 - Veterans with lower income
 - Veterans living in rural areas
 - Veterans without other access to health insurance coverage
 - Veterans with poorer self-reported health status
 - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

VHA's Four Missions

Overall Objective:

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Care Delivery	Develop, maintain, and operate a national health care delivery system for eligible Veterans.
Education	Administer a program of education and training for health care personnel.
Research	Conduct health care research benefitting Veterans and public
Emergency Response	Provide contingency support for Department of Defense (DOD) and Department of Health and Human Services (HHS) during times of <u>war or national emergency</u>

Our mission extends beyond healthcare for Veterans

VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

VA



U.S. Department
of Veterans Affairs

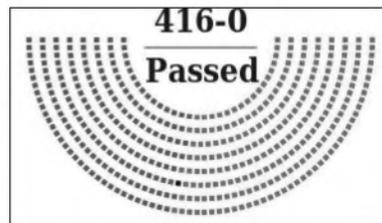
VA Healthcare Costs Not Found in the Private Sector

\$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	\$853	\$888	\$924
Camp Lejeune	\$10	\$24	\$21
Caregivers	\$454	\$623	\$725
CHAMPVA, Spina Bifida, FMP, CWVV	\$1,547	\$1,817	\$1,920
Comprehensive Emergency Medical Program	\$147	\$135	\$139
Dental Care	\$1,005	\$1,035	\$1,433
Health Professions Educational Assistance programs	\$37	\$56	\$70
Homeless Programs	\$1,507	\$1,477	\$1,591
Income Verification Match	\$17	\$19	\$19
Long Term Care	\$7,702	\$8,223	\$8,588
Readjustment Counseling	\$221	\$258	\$244
Rural Health Outreach Initiatives	\$219	\$270	\$250
Sharing Agreements - Services Provided by VA	\$157	\$157	\$166
Subtotal	\$13,875	\$14,980	\$16,090
Hepatitis C (assume 50% greater benefit)	\$406.1	\$500.0	\$500.0
Mental Health (assume 50% greater benefit)	\$2,283.9	\$2,494.9	\$2,610.6
Prosthetics (assume 50% greater benefit)	\$909.0	\$950.3	\$1,215.2
Subtotal	\$3,599.0	\$3,945.2	\$4,325.9
Total	\$17,473.9	\$18,924.9	\$20,415.8

Educational
Employment Services

20 Years of Increasing Demand for Services

- 1996 “Veterans Eligibility Reform Act”
- Conflicts in Afghanistan and Iraq continued
 - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 “The Veterans Access, Choice and Accountability Act”



- Enactment of Public Law 104-262, “Veterans Eligibility Reform Act” in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality is equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA



U.S. Department
of Veterans Affairs

Impact of VHA Research

VA



U.S. Department
of Veterans Affairs

VHA Priorities



U.S. Department
of Veterans Affairs

USH 5 Priorities for Strategic Action

<p>Access</p> <p>We will provide timely access to Veterans as determined by their clinical needs.</p> <p>PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs</p>	<p>Employee Engagement</p> <p>We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.</p> <p>PSA: We will work to allow staff to have greater input into their work environment.</p>	
<p>High Performance Network</p> <p>We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.</p> <p>PSA: We will build a high performance network of care to best serve Veterans.</p>	<p>Best Practices</p> <p>We will use best clinical practices. We also seek best practices in research, education, and management.</p> <p>PSA: We seek to identify and disseminate best practices throughout VA.</p>	<p>Veterans First: Trust in VA Care</p> <p>We will be there for our Veterans when they need us.</p> <p>PSA: We will share our results on the quality and timeliness of how we care for Veterans.</p>

Priority 1: Access Transformative Changes



MyVA Access
Declaration

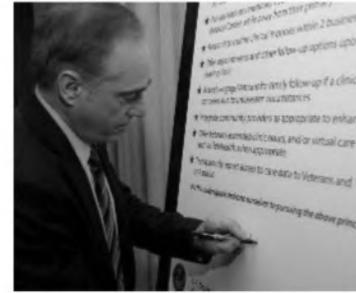
Prong 1

Prong 2

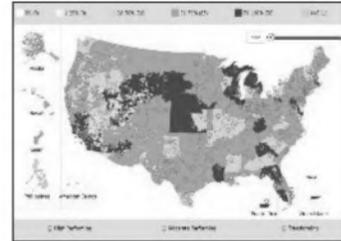
Access
Improvement
Solutions

National
Deployment
Strategy

Prong 3



*Dr. David Shulkin signing the MyVA
Declaration Statement on 4/7/2016*



19

VA



U.S. Department
of Veterans Affairs

Transformative changes heading

Prong

Guidebook

Map

Same day Services for urgent needs

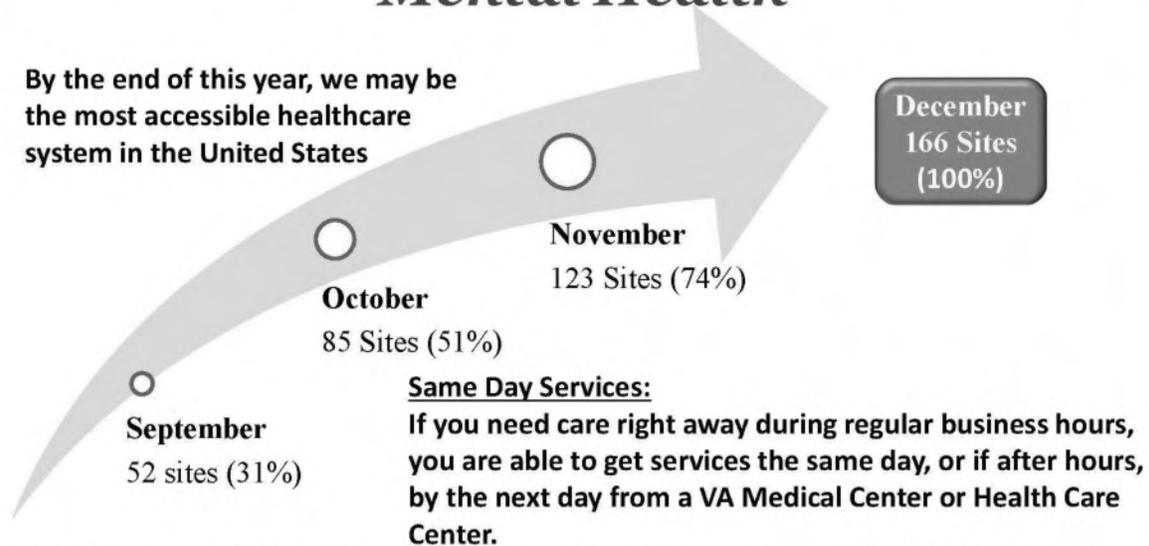
Path to SDA

Third slide is Results and impact that improve access

Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States



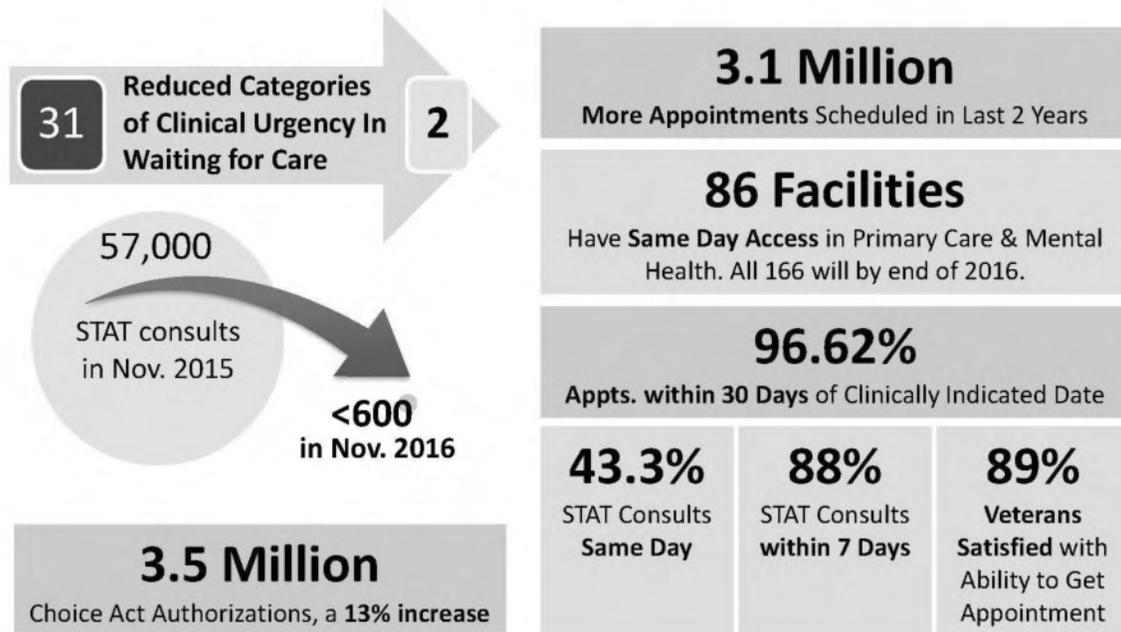
Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- For a medical emergency always call 911 or report to the emergency room closest to where you are located.

Priority 1: Access

Results that Impact Care



Draft / Pre-decisional / For Internal VA Use Only

21

VA



U.S. Department
of Veterans Affairs

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)

57,000 stat consults in Nov 2015 to <600 in November 2016

3.1 Million more appointments scheduled in the last 2 years

86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016

89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)

In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date

43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)

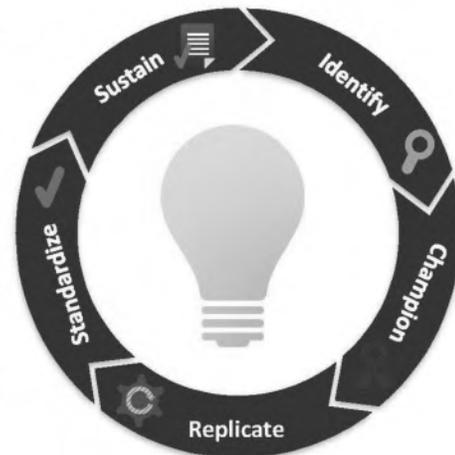
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16

Expanded scheduled hours on weekends and evenings, productivity, people, and space

More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

Priority 2: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
 - **85** of those replications have been completed **within 9 months**
 - **301** of those replication projects are **ongoing and on track**
 - **Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only

23

VA



U.S. Department of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:

1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	% Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	% Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
		VETERANS EXPERIENCE	BRAND	“I trust VA to fulfill our country’s commitment to Veterans”	55%
	EFFECTIVE	“I got the care or service I needed”	72%	74%	75%
	EASE	“It was easy to get the care or services I needed”	61%	65%	66%
	EMOTION	“I felt like a valued customer”	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

VHA Accomplishments in 2016



Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders

**Be there
for someone in your life.**

Connect fellow Veterans and Service members in crisis with support.

VeteransCrisisLine.net



U.S. Department
of Veterans Affairs



Veterans
Crisis Line
1-800-273-8255 PRESS 6

Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans.**
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010, **over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations:
http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

Public Health Issues

Hepatitis C Management

- In FY15 & 16, VA treated a total of **69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health



Building a Stronger Organization

- Recruited **new Principal Deputy Under Secretary for Health (PDUSH), Deputy Secretary for Health for Operations & Management (DUSHOM), 2 Assistant Deputy Under Secretary for Health (ADUSH positions), and all Deputy Under Secretary for Health (DUSH positions)**
- **8,490** new staff trained in **lean management**



5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

Serving our Veterans and the Nation

Culture of Improvement

- 6th year – VA's pharmacy benefits ranked among best in class
- 24 million in cost avoidance through our supply chain efforts
- An Integrated operations center to proactively monitor and identify issues in quality or access
- 23,000 pounds of used medications returned and destroyed this year

Service to the Nation

- 9,860 research publications in 2016
- Added 547.4 graduate medical education positions
- Responded and deployed to 6 national emergencies



VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:

Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

82% of VAMCs with Improvement *SAIL Quality Measures in Past Year*

FY16Q3 SAIL Quality Star Percentile Cut-Off						
Overall Quality FY15Q4-FY16Q3 ¹	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17²	31²	55	28³	15³	146⁴

Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

Studies showing better outcomes
JAMA

Comparing VA Care to Private Sector

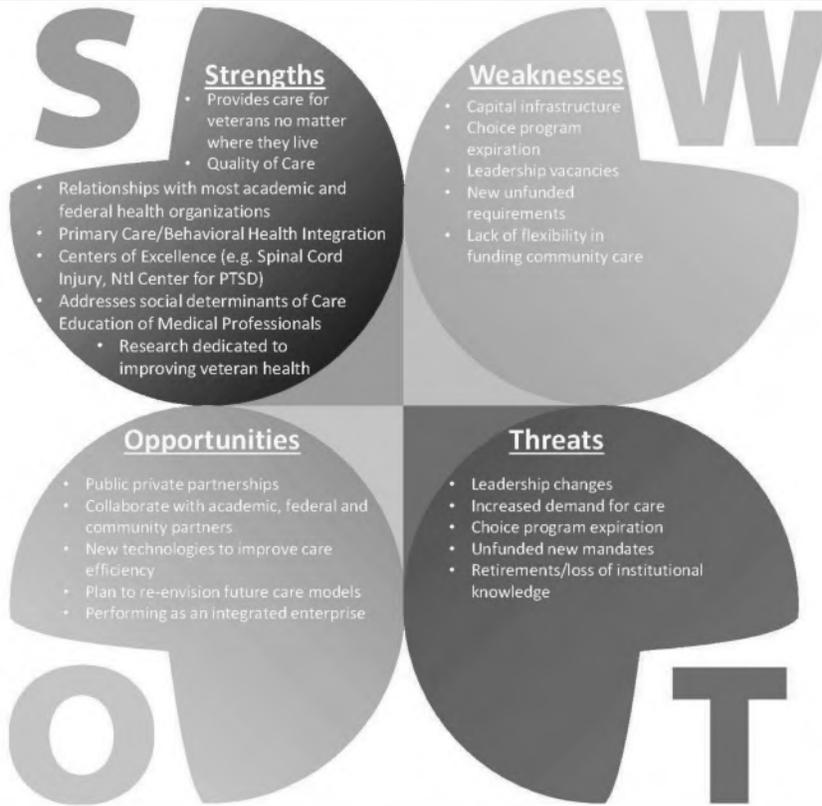
- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment



More data in press release: <http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778>

Future Direction, Priorities and Opportunities





Increasing Demand

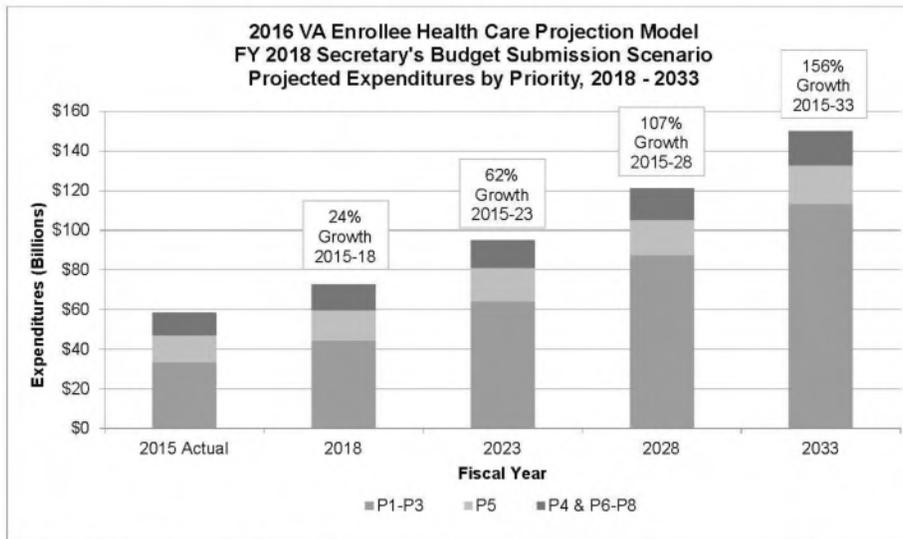
- VA completed nearly **5 million more appointments** in 2015 than in 2014 (FY 2016 data not yet available)
 - Almost **57 million appointments inside VA** and over 21 million in the community.
 - For Veterans that means **over 7 million additional hours** of care
- Veterans are aging and will need **more complex care and long term care** and support services
- Reliance on VA may grow as costs of other insurance and exchanges may increase
 - **Each 1 % increase in reliance is a cost of approximately \$1B**

3rd bullet notes:

In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

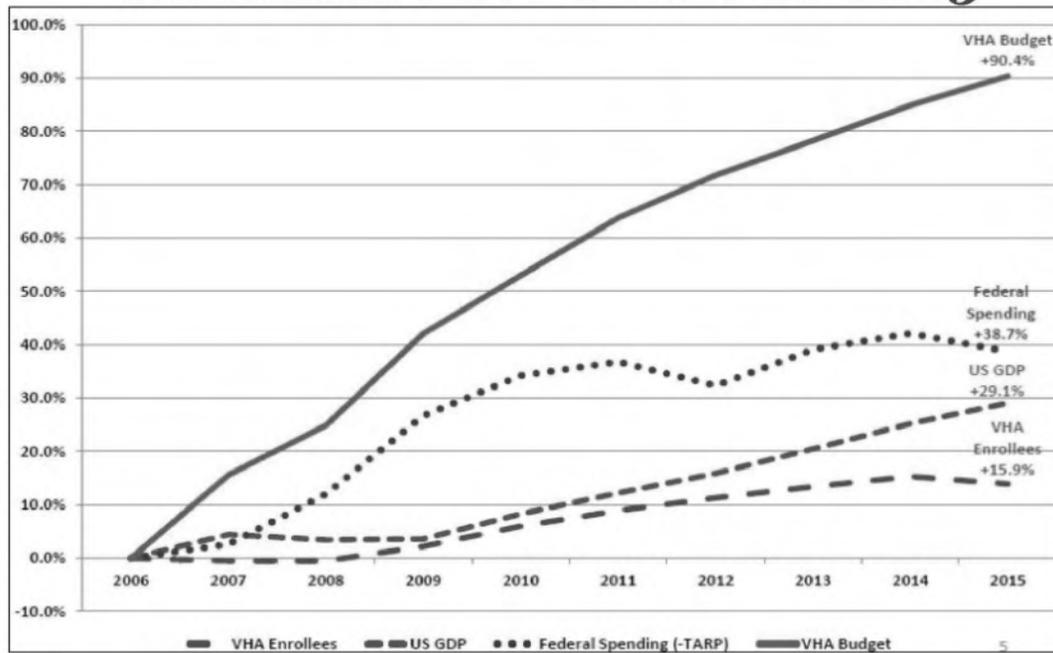
Latriece mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

VA's Resource Requirements Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

VA Medical Care Budget Challenge: Cumulative Growth 2006-2015



2018 Budget

- VHA's FY 2018 Advance Appropriation is **\$2.8 billion less** than the total funds available in FY 2017 – a 4% decrease
- Choice Program ends 8/7/17 (**\$3.3B per year**)
- Other risks that may impact future years -These items were not included in the FY 2017 enacted budget, which includes the FY 2018 Advance Appropriations
 - \$0.5-\$1.5 Billion – Staab Court Case (Emergency Care) May generate increased future utilization \$1-\$2 Billion
 - Presumptive Service Connection – Camp Lejeune Reservists
 - In Vitro Fertilization
 - Comprehensive Addiction and Recover Act (CARA)

Bullet 3: Estimated budget numbers:

IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds

Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate

CARA = \$153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:

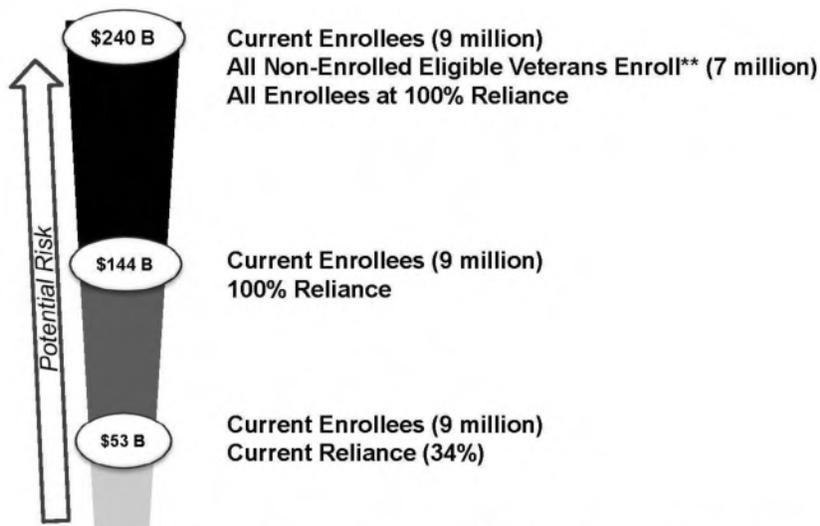
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

Potential Changes in Veteran Enrollment & Reliance on VA Health Care*



*FY 2014 actual and projected expenditures from the 2015 VA Enrollee Health Care Projection Model for modeled services: excludes readjustment counseling, Caregivers, CHAMPVA and capital expenditures.

**Note, approximately 6 million of the 22 million Veterans in 2014 were not eligible to enroll in VA health care due to income.

VA



U.S. Department of Veterans Affairs

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was \$53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been \$144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been \$240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

Priorities for the Next Administration



Continuity of Leadership during a Crisis

Leadership vacancies and succession planning

Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust

Direction of the Commission on Care Recommendations

Supporting VHA's Course for a Future Vision

Legislative Areas of Focus

- Choice Act Authority Expires 8/7/17
- Legislative fixes to “Care in the Community”
- Critical Pay for Medical Center Directors (1A) and VISN leaders
- The 80-hour pay period
- Special pay authority for VA health care senior managers
- Budget flexibility needed

3RD BULLET:

The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

Attached for reference is the signed/dated letter from OPM regarding critical pay.

Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare



Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans



A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students



Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/2/2016 8:08:50 PM
To: [REDACTED]@gmail.com
Subject: vso slides
Attachments: vso110916.pptx



VSO Breakfast November 9, 2016

David Shulkin, M.D.
Under Secretary for Health
Department of Veterans Affairs

November 22, 2016



U.S. Department
of Veterans Affairs

DAV 7/31/16



ELECTION RESULTS

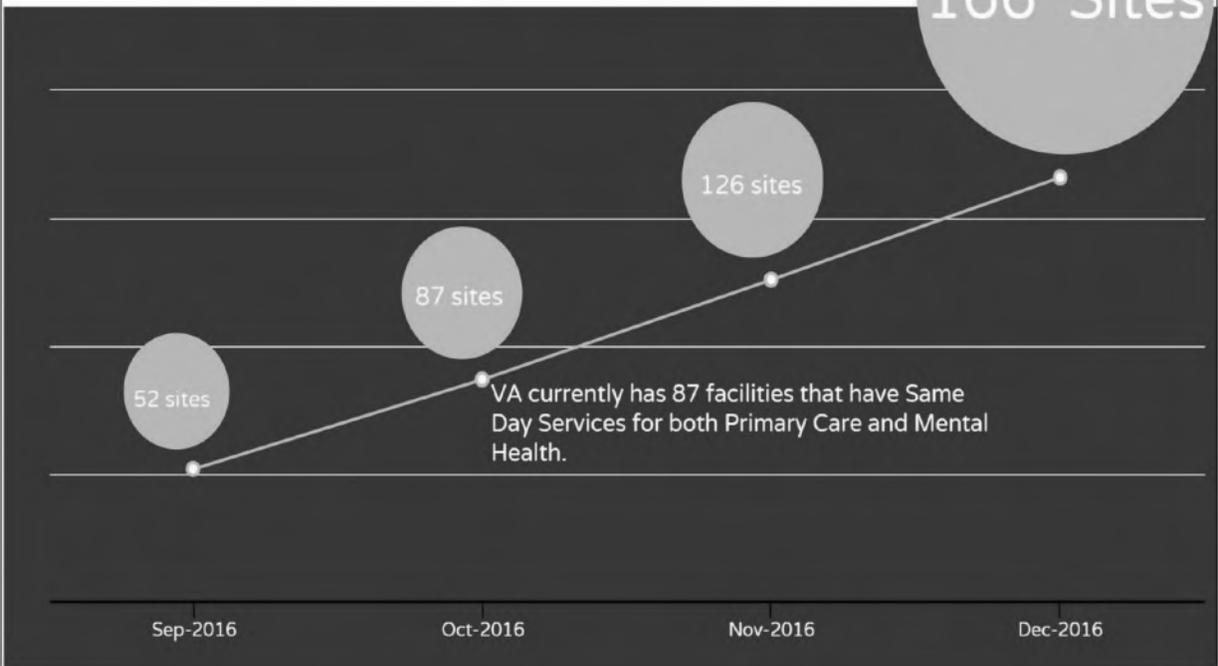
A graphic featuring a stylized American flag with stars and stripes, overlaid with the text "ELECTION RESULTS" in large, bold, black letters.

VETERANS HEALTH ADMINISTRATION

Have We Made Progress? 5 Priorities

- Access
- Best Practices
- Employee Engagement
- High Performance Community Network
- Trust

Timeline to Same Day Services in Primary Care and Mental Health

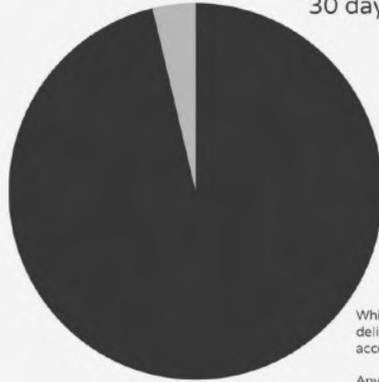


Timely Appointments

Veterans are able to receive an appointment when needed

96.5%

of all Veteran appointments were completed in less than 30 days.

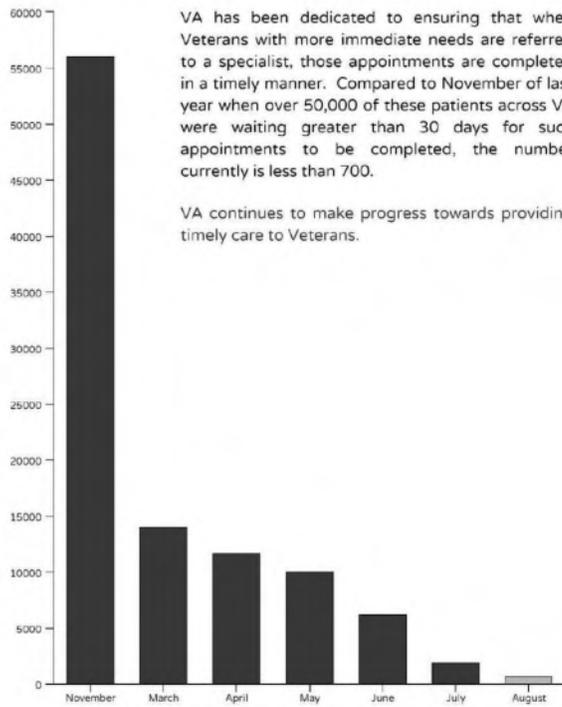


● Completed ● Not Completed within 30 days

While VA has experienced improvements in delivery of outpatient services, optimizing access remains its greatest priority.

Any patient waiting over 30 days for an appointment is offered the option of receiving care in the community via the Choice Program. Despite the increasing appointment requirements, VA is completing 96.5% of all appointments within 30 days, 85.2% within 7 days; and 22.3% of all appointments the same day.

Veterans waiting over 30 days is significantly decreasing

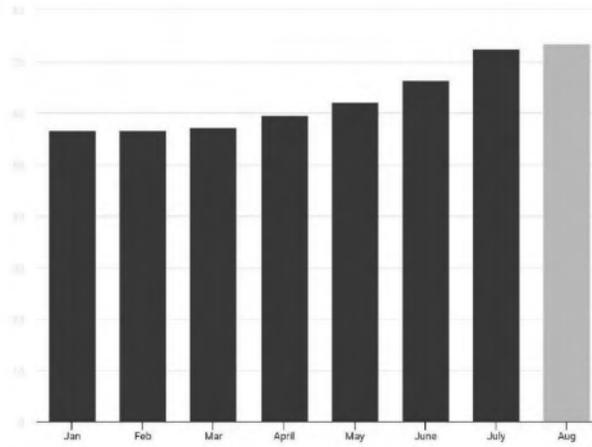


6

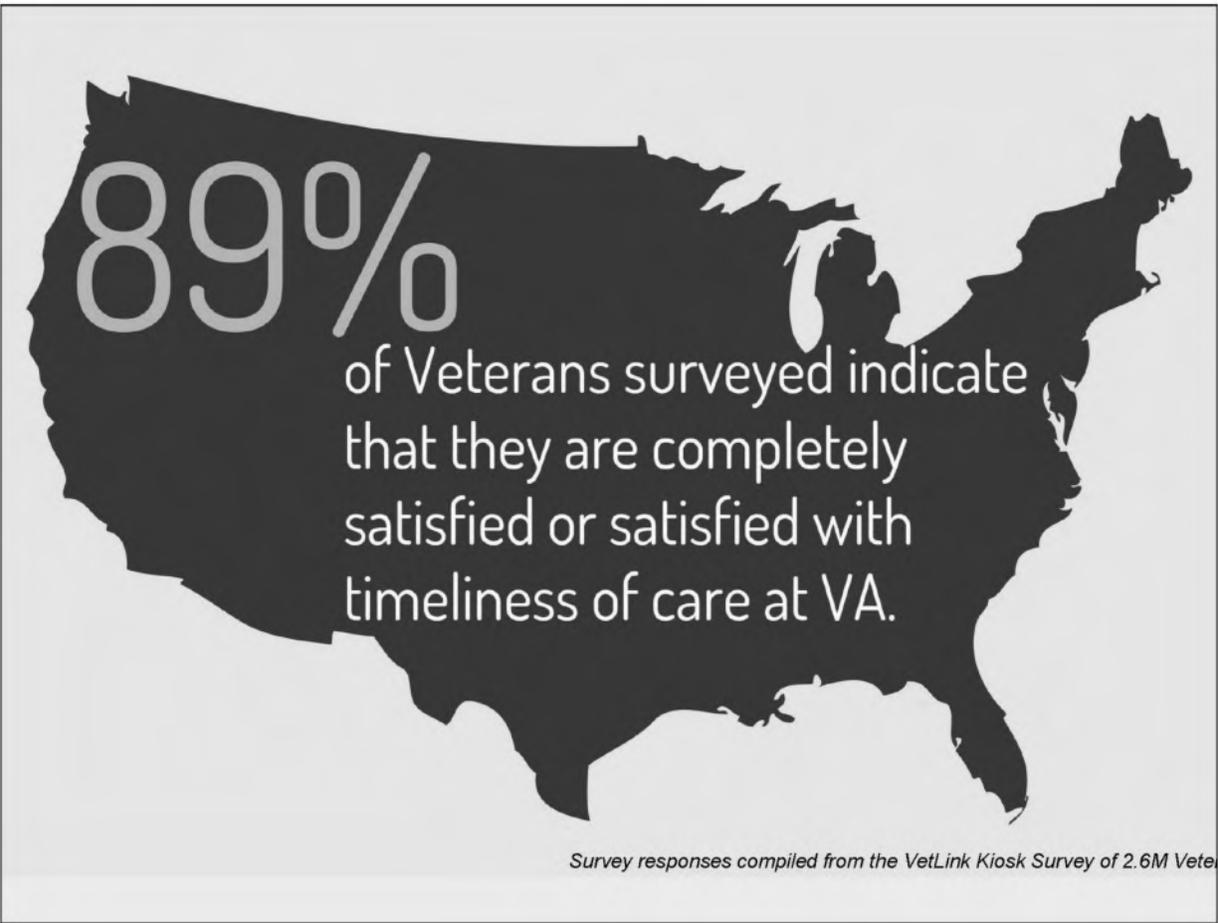
Source: Veteran Health Administration Support Service Center

The number of Veterans with more immediate needs seen within 7 days by nearly 20%

VA is dedicated to ensuring that when Veterans with more immediate needs are referred to a specialist, those appointments are completed in a timely manner. In January, VA was able to complete these visits within 7 days - 57% of the time. As of August, VA has increased that number to 74% of the time.



% of Closed Consults within 0 to 7 Days based on August 2016 VA Public data.



CAPH Scores- Most challenged sites

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered “clinically significant”

WHAT ABOUT THE 500 K > 30 DAYS?

- Last Fiscal Year, VA completed 58 million appointments
- VA has 7.2 million scheduled appointments at any time
- Elimination of recall is adding to the list of those with scheduled appointments
- 518,000 are scheduled over 30 days from Clinically Indicated Date (CID)
 - Half are clinics for lesser problems, e.g. physical therapy, audiology, podiatry
 - Of the remaining 250 K, 80% are existing patients
- 45 K are new patients that have not been seen yet- which is why same day services are being made available for care needed right away
- All patients waiting over 30 days from CID are eligible for Choice

Public Wait Time Data and Interactive Maps



U.S. Department of Veterans Affairs

site map [n-j] [i] [e] [f]

What Veterans say about Access to Care at VA facilities

Location (zip, city/state, full address) Radius Appointment Type Sort Results By Search

Percent of Veterans who reported that they were Always or Usually able to get an appointment when needed. These results are for the period 10/1/2015 - 3/31/2016. At least 30 Veterans have responded to this question for a site to be included. The filters used to search are: 50 mile radius of phoenix, az; Primary Care (Routine) appointments.

Note - The data shows what Veterans have said about their own Access experiences over the preceding 6 months. Your own experience may be different. For urgent problems, there often are options to be seen sooner, such as a same-day clinic. If your wait will be longer than 30 days, you may request a referral to Care in the Community.



VETERANS HEALTH ADMINISTRATION

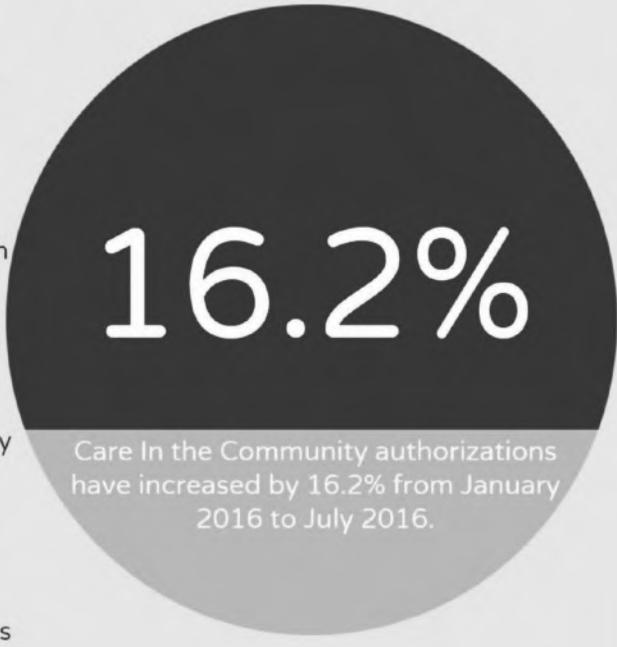
Choice Authorizations

On August 7, 2014, President Obama signed into law the Veterans Access, Choice and Accountability Act of 2014 ("Choice Act").

The Choice Program provides Veterans with the flexibility and ease to see a provider within their community if:

- VA cannot schedule an appointment within 30 days of the Veteran's preferred date, or
- the date determined medically necessary by a provider, or
- if the Veteran resides more than 40 miles from their closest VA medical facility.

The data reflects the number of authorizations Veterans have received to see a provider in the community.

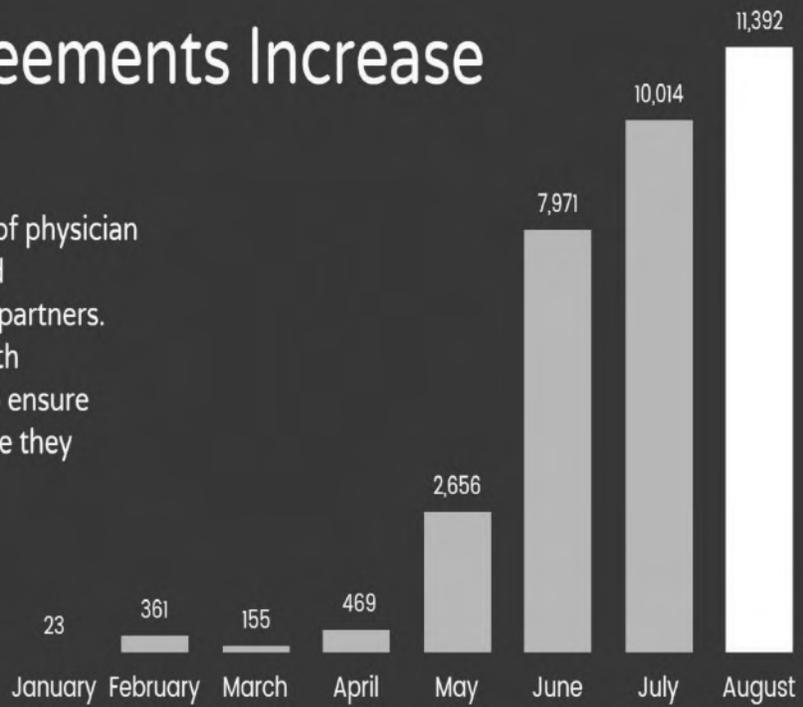


16.2%

Care In the Community authorizations have increased by 16.2% from January 2016 to July 2016.

Provider Agreements Increase

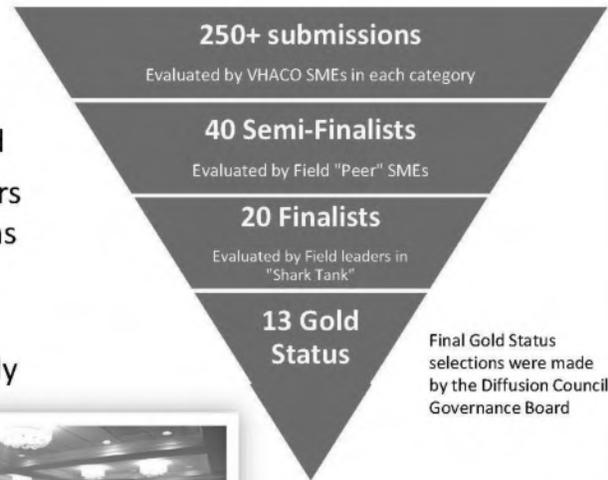
This data reflects the increase of physician agreements VA has established independent from contracting partners. VA is focused on partnering with physicians in the community to ensure Veterans receive the timely care they need.



Choice Contractor Dashboard, VHA Support Service Center, July 2016

Diffusing Best Practices: Leverage Private Sector Practices

- ✓ **300** Internal submissions for first Under Secretary for Health (USH) Promising Practices competition
- ✓ Over **400** Submissions to next round
- ✓ **28** Medical Center and VISN directors committed to this effort by serving as the first Shark Tank "Sharks"
- ✓ **368** ongoing replications of best practices, **70** of which are completely replicated
- ✓ **70** Sites participating in the Initiative



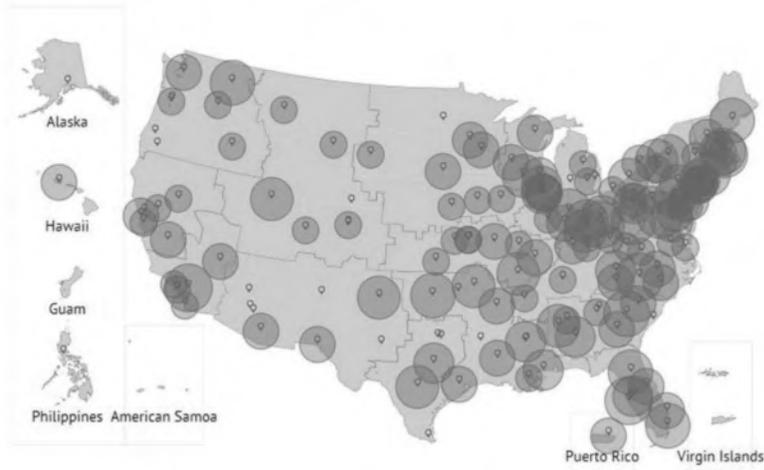
VETERANS HEALTH ADMINISTRATION

14

Shereef

In under **6 months**, over **260 implementations** at over **70 Facilities** across the country

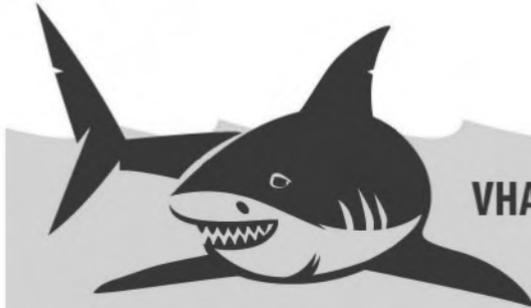
Legend  Number of Projects  VAMC or VISN Office VHA



VETERANS HEALTH ADMINISTRATION

Next USH Shark Tank: November 2016

- Improving Access to Care
- Establishing Robust Care Coordination/High Performing Networks
- Increasing the Morale and Engagement of Employees
- Building Trust in VA Care/ Improving the Veteran Experience
- *Improving Quality and Safety (always a priority)*



**VHA Shark Tank Submissions
NOW OPEN!**

Specific Topics of Interest

Opioid Safety and Pain Management

Mental Health

Cancer Moonshot

Rural Veterans

OIF & OEF Veterans

Women Veterans

Kidney Disease Management

Tumor Board

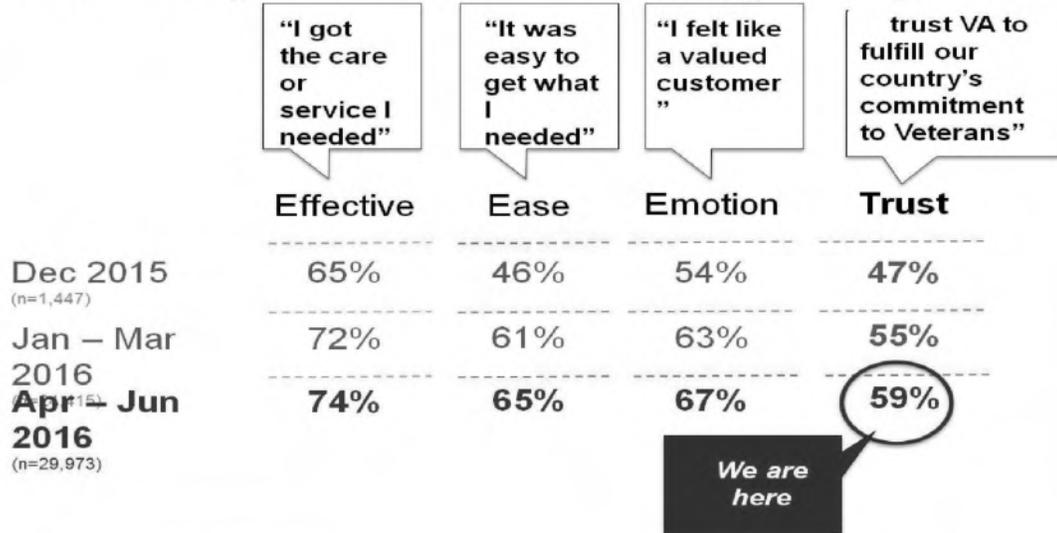
Community Care Health IT Solutions

Employee Engagement

	2014	2016
"I recommend my organization as a good place to work"	3.66	3.70
Average AES Score	3.45	3.58*
		*Only year in past 10 it had been higher was 2011 when it was 2.66

TRUST

Veteran Experience metrics are improving



Progress in Quality

82% (120/146) Medical Centers saw an improvement in SAIL scores in FY 16

REACH VET Program



- Started nationwide at the end of October

Identifies veterans at 33X risk of suicide in one month and 81X the risk in one year

VETERANS HEALTH ADMINISTRATION

20

REACH VET uses innovative statistical methods based on VA data to identify VA-enrolled Veterans at risk for suicide and other negative outcomes.

REACH VET is a supplement to current clinical strategies of identifying patients at increased risk.

REACH VET identifies Veterans at increased risk and notifies providers of identified Veterans, so providers can reevaluate and enhance the Veteran's care.

REACH VET enhances at-risk Veterans' access to care and complements ongoing initiatives to increase access.

REACH VET starts nationwide in October 2016—it will identify thousands of Veterans with complex care needs across the country and ensure they are receiving the very best evidence-based care.

Identified At-Risk Veterans Provide Opportunities for Enhanced Care

Of those in the top **.1%**, only **30%** were identified as high risk for suicide based on clinical signs and symptoms

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 12/29/2016 4:46:22 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Scott Blackburn

Spoke to him about Toby- in fact he encouraged me to talk to him on his cell directly- he will send me his contact information and I will send to you, after which we can discuss the approach

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/30/2016 12:53:59 PM
To: [REDACTED]@hotmail.com
Subject: Re: See attached

yes this would be very cool

-----Original Message-----

From: Poonam Alaigh [REDACTED]@hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Fri, Dec 30, 2016 7:45 am
Subject: See attached

I am still grading papers today- doing this one from the DoD- you have to review it- right up our alley- this is the kind of consulting stuff with can do and bridge to our VA stuff and NAOHH- tell me what you think

Message

From: Poonam Alaigh [redacted]@hotmail.com]
Sent: 12/30/2016 12:44:32 PM
To: David Shulkin [drshulkin@aol.com]
Subject: See attached
Attachments: Max Executive Summary.docx

I am still grading papers today- doing this one from the DoD- you have to review it- right up our alley- this is the kind of consulting stuff with can do and bridge to our VA stuff and NAOHH- tell me what you think

EHSY 711 Integrative Seminar II
Project Write-Up
Max Clark

How can Separation Health Physical Exams (SHIPs) and other Medical Readiness exams be completed properly & efficiently outside of the Medical Home (MedHome) for the US Navy?

Executive Summary

Navy Medicine has been informed that its completion rate for SHIPs is approximately 25%. This violates instruction and potentially delays Service members from obtaining a disability rating from the Veterans Administration. MedHome clinics were initially designed to offer a full spectrum of services, to include SHIPs. After the roll-out of MedHome clinics throughout the enterprise, in addition to the lackluster completion percentage of SHIPs, access at the clinics has also been suboptimal. It was at this point, a project was chartered to address the SHIP metric, while (hopefully) improving access at MedHome clinics; this was the genesis of the Medical Readiness Clinic (MRC).

MRCs are designed to address core medical readiness exams. The charter specifically includes: Periodic Health Assessments, Deployment Health Assessments, Overseas Screenings, Sea Duty Screenings, and SHIPs. It is probable MRCs could include other readiness exams, but at launch that determination will be made by local commands. MRCs are purposely not designed to deliver care, they are for appropriate medical decision making. They are to highlight any potential injuries or illnesses that could affect a Sailor's or Marine's ability to execute their orders so a commanding officer may make an informed decision. Also, by specializing in medical readiness exams, they should steadily improve at their execution quality and efficiency. It is expected that specialization and repetition will improve both of those qualities. MRCs are designed to be specialists of military medical readiness.

A core team was created at chartering to include key stakeholders such as patient administration, MedHome, Navy Regional commands, etc. After informal discussions, the Navy Regions selected three pilot sites to test the concept: Pearl Harbor, HI; Sewell's Point Clinic of Norfolk, VA, and Gulfport, MS. They are being measured by standing readiness metrics and SHIP completion percentage; feedback from Navy commanders will also be incorporated once the pilots are functioning fully. So far, the clinics have seen a modest rise in SHIP completion

percentage of approximately 10%. As 2017 looms, the rollout of the new Periodic Health Assessment and a push to overhaul the entire Suitability Screening process pose additional serious hurdles for the MRC concept. The primary hurdle is that these processes individually will require substantial manpower and effort; the MRC concept is already suffering from a severe shortage of both. MRCs could help with both issues but long-simmering problems that are likely to be exposed by the new processes will create turmoil throughout the enterprise. 2017 will be vital year to help establish a foundation for success or failure.

Full Write-Up

Prologue:

Several years ago, the Bureau of Medicine and Surgery (BUMED) adopted the Medical Home (MedHome) model for the delivery of primary care. As part of this merging of multiple health care functions into the MedHome, medical readiness exams were also rolled into the MedHome model. The MedHome was designed to be a one-stop shop for all the primary health care needs a Sailor, Marine, or their dependents would need. However, after several years, problems began to emerge. Medical readiness exams were completed with variable quality and access to the clinic for all patients was suboptimal.

Of note, it was reported to BUMED leadership that the Separation Health Physical Exam (SHPE) completion percentage for the Department of Navy was approximately 25%. It seems extremely probable the real number is higher, but data collection fails to fully account for this. This could be due to improper coding, SMEs getting done by the VA and it not being reported, or a myriad of other reasons. All Sailors and Marines are required to have a SHPE prior to separating or retiring from active duty service, unless they have been found medically unfit to serve and are medically separated or retired. The SHPE can be completed by Navy Medicine personnel at a military treatment facility (MTF), Navy Medicine personnel attached to an operational Navy or Marine units, or Veterans Administration (VA) providers at a VA facility. Navy Medicine should clearly be able to track SHPEs done at Navy MTFs, but it would be very difficult to track those done on a Navy aircraft carrier, USMC clinic, or VA facility. Furthermore, Service members (SMs) face no real penalty if they choose to forgo their SHPE.

So even though SMs had multiple options for completing a SHPE, Navy Medicine is responsible for improving their completion percentage.

When this issue was briefed to senior BUMED leadership, the then MedHome program manager saw an opportunity; specifically address the SHPE issue while removing it from MedHome and theoretically improving access. As challenging projects are wont to do, they roll downhill. I was approached to spearhead a solution and I immediately had a potential solution. I was not shy in my ambition to address what I felt was poor attention paid to medical readiness. It had been unevenly executed and taken for granted for years, at least in my anecdotal experience. Furthermore, I had seen too many solutions fall apart because they were designed to be short-term fixes, only to see the problem raise its head again later on in the future. So from literal day one of the discussion stage, I proposed the Medical Readiness Clinic (MRC) concept. I did not meet initial resistance that afternoon, and have pushed forward ever since.

Project:

MRCs are to become the MedHome equivalent for medical readiness. Standardized processes, expertise through training and specialization, and a single belly button for SMs will be what set them apart. Currently exams that will be contained in the MRC can be located in several departments of an MTF causing the SM to bounce around with little to no coordination amongst departments. Staff sometimes feel forced to complete these exams and their disdain can be reflected in poorly executed exams. Important preventive screenings can be missed. SMs can be sent out to sea, only to be sent right back due to an overlooked medical condition; this comes at considerable expense to the Navy. With no defining standard, MTFs create local processes that sometimes are not supported by instruction or evidenced-based medicine.

So what is medical readiness? It is the process that ensures Sailors & Marines are prepared to fulfill their assigned duties in an orderly & rapid fashion, without being encumbered by medical (including dental) injury or illness. It is an Occupational Medicine (OccMed) examination; in this case the general occupation is Sailor or Marine. Occupational Medicine has a clear clinic component, but what sets it apart is the medical decision making. OccMed physicians have been specifically trained to make appropriate medical decisions in regards to an individual's occupation. A general surgeon has the skills to remove a uterus, but most people prefer a gynecologist to perform the surgery due to their specialty training. Ergo, why not utilize

Commented [PA1]: It is so good to see your ability to be proactive as a leader regarding this. But when addressing in a paper, it is always good to remain objective and inclusive, giving a sense of team based and led solutions.

the skills of a specialty trained physician to create clinic environments where key medical decisions are being made? Sadly, Navy Medicine does not have enough OccMed providers to supply every MRC, but nearly every MTF has an OccMed provider that could be used to help resolve challenging cases.

Medical readiness begins before an individual even joins the Service. They undergo a thorough history & physical to determine if it is medically appropriate for them to join the Service. That exam is well beyond the scope of the MRC, but making medical readiness determinations does not stop upon entering the Service. Every SM in the DOD is required to get a Periodic Health Assessment (PHIA) every 12 months. This process is defined by a soon-to-be-released Department of Defense Instruction (DODI) and current Secretary of the Navy Instruction (SECNAVINST) 6120.3. It determines the minimum elements required by every Sailor and Marine, such as which immunizations they need or how healthy they should be dentally. Before a SM is deployed, they have to be screened medically. Upon returning from that deployment, often a combat zone, they are screened several times; largely to identify mental health issues as soon as possible. These steps are lumped together in a category called Deployment Health Assessments (DHAs). When a SM gets orders to go underway aboard a Navy vessel, they must be screened medically. When a SM gets orders to go overseas (e.g. Guam) or a remote location (e.g. Key West) they are screened to ensure any medical conditions, presuming they have any, can be treated at that destination which is unlikely to have many medical specialties. Finally, before leaving active duty, the SM is screened one last time with the SHIPF to ensure they are medically ready to leave. This is mostly intended to prevent a SM from leaving the Service while dealing with an acute injury or illness. An example I personally dealt with, a SM had shoulder surgery six months before he was scheduled to leave active duty. However, he had a complication from the surgery and his active duty departure was delayed months until he reached maximal medical improvement.

A core team was assembled with some key stakeholders: Patient Administration representative, contractor with plentiful project management experience, representatives from each of the two Navy Medicine regions, operational medicine representative, a MedHome representative, and I. Customary with uniformed military, they rotate with regularity and the Core Team has dealt with this as well: reps have been replaced and there have been multiple occasions when ad hoc experts to asked to join our weekly meetings. BUMED even allowed

early on site visits to Pensacola, FL, and San Diego, CA to look at a variety of clinical settings and to obtain a voice of the customer. Pensacola in particular was of interest due to their own version of a MRC they had set up several years previously. We have stayed in contact with Pensacola's clinic manager to bounce ideas and learn from their experiences. The most telling lesson was his opinion that their success was largely due to two things, their commitment and strong command support.

After researching a variety of issues (e.g. collating relevant instructions, how these exams are done throughout the enterprise, etc.), it was felt we had enough to move forward with pilots. [In retrospect our plan was not sufficiently detailed enough and we failed to get direct support of leadership of our specific goals. We had permission to proceed but even after a year, leadership has yet to request a briefing or formal update]. After pre-consultation, we received approval from BUMED leadership to formally solicit the selection of at least one pilot site from each region. Navy Medicine is split into two regions, West (NMW) and East (NME). NME choose Branch Health Clinic (BHC) Gulfport which is a BHC of Naval Hospital Pensacola and BHC Sewell's Point which falls under Naval Medical Center Portsmouth. Gulfport was chosen to its closeness to Pensacola and their expertise. Sewell's Point was chosen due to their high fleet concentration, proximity to NME offices, and large volume. NMW choose Naval Clinic Hawaii which operates several BHCs on the island of Oahu; only the two main clinics will be involved with the pilot. Hawaii was chosen due its variety of customers: Marines, ship-board Sailors, assorted Naval personnel, and random other DOD personnel. Gulfport was been able to start on 1 July 2016. Hawaii began (SHPE only) on 1 August 2016. Sewell's Point, delayed due to command turnover, started 1 September 2016.

With the pilots starting asynchronously, and other BUMED responsibilities, it has been challenging to provide the oversight necessary to ensure the pilot's SOP are as identical as possible. Despite the creation of the core team, manpower can be in shortly supply and deadlines have shifted to the right several times. We also spent a fair amount of time determining which metrics would be appropriate to measure. We wanted metrics to be able to demonstrate an effect, if any, but also for the metrics to have actual value; it would be counter-productive to simply create another outcome-meaningless number to chase. We determined, as imperfect as it is, to use SHPE completion percentage as the sole SHPE metric. A handful of other existing medical readiness metrics will be imported but I refrain from mentioning them further in the

Commented [PA2]: Is this something that we can address in the upcoming semester IS 3

interests of time. We are even still considering trying to develop an access metric to see if the MRC has a demonstrable effect on access to the MedHome clinics.

I have personally encountered some primary care managers (PCMs) who were near apoplectic that exams they were used to doing would be pulled from the MedHome because they “knew their patients best”. A PCM should know their patient best, but these PCMs fail to see the true purpose of readiness exams. Using one of my Gallup strengths (harmony) my solution aims to thread that needle. PCMs may opt to perform readiness exams on their patients but they need to be reviewed by the MRC provider. Therein lies another problem, staffing. As Navy Medicine went all in on the MedHome model, employees or even whole departments were cut that performed readiness exams. It will likely take 1-3 years before staffing across the enterprise could be where it needs to be to fully support MRCs without borrowed labor. In the meantime, it is very conceivable that MedHome providers will need to be borrowed to execute readiness exams. In that scenario, we have strongly recommended that those borrowed providers dedicate a whole morning, afternoon, or day to doing readiness exams while utilizing a specific billing code (which is purely used internally). Due to these staffing issues, it is possible that the MRC model would work at MTFs or large BHCs with robust staffs, but would not work at smaller BHCs. In that scenario, I suggest certain exams (e.g. SHPE) be pulled back to the MTF so sufficient caseload keeps that skill fresh. The exception being remote BHCs (i.e. it would seem unreasonable for a Sailor in Key West to drive the 9 hours to Jacksonville for a SHPE) would have to have mini-MRCs. Hopefully these pilots will tell us if that is a true limitation or not.

The gears of the government grind slowly. Final metrics to be agreed upon took months. Some of this was due to personnel turnover and a lot of it was due to lack of prioritization. The only new metric created was SHPE completion percentage which is problematic, but smart people have been unable to arrive at a superior solution. It was suggested to possibly examine access for the MedHome clinics to see if the MRC was helping them as a secondary benefit. However, there was disagreement on how this could best be measured so it was shelved until a proper solution could be found. So far reports have shown a modest rise of 10% in the percent of SHPEs completed at the pilot sites. It would be premature to say it is solely because of the MRCs but it does suggest they are helping. However, a formal review of the metrics and a presentation to leadership did not occur in 2016. It is hoped in early 2017 that formal data review could occur and then presented to leadership with several courses of action.

Commented [PA3]: Key barrier, but important to keep this objective- maybe something like “the care teams were resistant to change and embracing a new concept to meet the needs of the SM” or something

Commented [PA4]: Explaining this as part of the “dependencies” or “barriers” or “risks”

Commented [PA5]: Is this something that can be improved and addressed in IS 3?

Commented [PA6]: This should be part of the conclusions and outcomes

Commented [PA7]: Definitely part of the scope that needs to be addressed

PHA & Suitability Screening:

In 2016 the Services collectively agreed upon a single Service PHA to be implemented across the Services. The PHA is essentially an annual review of a member's health status and significant risk factors for disease in order to make a rudimentary determination of their medical readiness. It was a major coup to get all the Services (Army, Navy, Air Force, Marines, and Coast Guard), including the Reserve and National Guard components, to agree to a single one, instead of the different ones that had proliferated over the past 10+ years. Another reason is Congress mandated an annual mental health assessment [MHA] with the Jacob-Sexton act in 2016. In order for the Navy and Marine Corps to comply with this, they could either keep their existing PHA (which is fairly Jackluster) & add the MHA separately or they could go with the new PHA which has a MHA embedded in it. The Chief of Naval Personnel and Commandant of the Marine Corps made their choice clear when they testified to Congress that the new PHA in 2017 would fulfill the Congressional mandate.

Many providers have qualms with the PHA. Some think everyone should get a full physical every 5 years as once was practice. Some don't want any assessment at all. Some think they are smarter than the dozens of professionals who contributed to the project. Many people think this is an opportunity to kill the PHA altogether. However, that option is gone; there is no plan B to implement the MHA separately (Navy-wide). There is a possibility that the Reserves (Navy & Marine Corps) will struggle to implement the new PHA for several reasons but the main are lack of providers, poor internet connections, and/or lack of available computers at Reserve centers. The last two are especially surprising since this is the 21st century, but that is the reality. The fleet's issues are somewhat self-induced. Ships and subs are extremely guarded about what software and hardware can be used on board. So PHAs done while underway will likely be done on computers using "store & forward" (completed PHAs are stored until the ship is in port with a hardwire connection and then uploaded to the main server in Virginia). It does seem likely that the Navy (or Navy Medicine) will need to buy laptops for each ship so SMs while underway can do their self-assessment portion while medical staff performs other necessary functions. The single biggest hurdle for the new PHA is the manpower issue. The PHA was designed to have some thought put behind it with actual deliberation about the SMs medical readiness status at the end. Instead it evolved into a check-in-the-box, often completed in minutes by a junior non-provider. Provider effort was directed into other needed areas.

providers are pulled in many different directions. The new PIA requires provider involvement; there are very few shortcuts that can take place. As this realization is beginning to hit commands, they are panicking. A very hard truth is about to be exposed about what the priorities should be for Navy Medicine providers.

A pilot is already underway at BHIC Sigonella, Crete. The BHICs of Naval Medical Center San Diego is about to start in early January 2017. A Naval Reserve center is expected to start piloting in early February 2017. My fleet medicine liaison at BUMED has been very helpful in communicating to the fleet so they can start preparing, but that heavy lift may not be fully completed in 2017.

Suitability screening is a process that anecdotally seems perpetually broken. Before a Sailor or Marine can accept orders to a remote duty assignment (e.g. Key West, FL), overseas assignment (e.g. Japan or embassy duty in South Africa), and/or shipboard duty they must be screened medically. This seems logical to prevent a member from going to a location where a medical problem could exacerbate or prevent them from fulfilling the duration of their orders. Every Sailor has a sea story about a new Sailor who shows up with an obvious medical problem only to be sent back right away (a very fiscally costly process) and a new Sailor must be found to fulfill the billet (more costs incurred). Managing this product line was done by another department in my directorate. The former department head and I agreed the portions that pertained to the military (family members also get screening for overseas assignments) should have some involvement with me. Within the past two months, the department head has resigned in order to move to AZ and it will likely be months before her replacement is found. In early 2016, she led an effort to overhaul the instruction that governs the screening process. On paper potential improvements seem very promising. She had also gotten the Centers for Naval Analysis to take a look at some of the screening data to make approximations of the actual scope of the alleged problem(s) with it. That report is due to arrive in April or May 2017. Also, recently, very senior Navy leadership, including the leaders of Navy Personnel Command and BUMED, has clamored asking for a revamp of the system. Frankly it's been a lot of admirals screaming "do better" or at least "do something" without specific direction or focus. My boss has spoken with leadership and solicited multiple ideas from the departed DII and myself. However, leadership has not relayed back to me what they want to do, how to do it, or when to do it.

On a personal note at work, another major hurdle has been my new assigned responsibility. On 30 June 2016, the Secretary of Defense announced transgender [TG] SMs would be able to serve openly, receive TG-related health care, and be accessioned into the armed forces. Although not completely unexpected, this announcement set waves of furrowed brows across the DOD. That same afternoon, I was told by leadership I would be the official point of contact for TG issues at BUMED by the Deputy Surgeon General of the Navy. For the first four months, nearly all of my work time went into TG issues. Policy had to be created, meetings had to be built, leadership needed to be briefed, and questions from all over had to be answered. Even only being the Action Officer to the Captain subject matter expert, many man-hours were spent to create new policy and guidance in an incredibly short timeline. The demands have lessened for sure, but it has made a significant deleterious impact to my ability to focus on anything else. I feel responsible the MRC project has slowed to a crawl due to my severe lack of time & energy. I am trying to find a much more appropriate permanent home for it, but I fear leadership could insist I stayed involved for several more months. I sincerely hope that is not the case.

Future State:

When the pilots are fully analyzed in early 2017, a determination will be made what the ultimate future of MRCs will be. Should they be rolled out to every Navy health care facility? Should the entire project be shelved? I believe MRCs will function best at large MTFs (e.g. Naval Hospital Camp Pendleton) and very large BHCs (e.g. Sewell's Point in Norfolk, VA). From these core MRCs they can support smaller facilities in a hub & spoke fashion. Some exams (possibly SHIPs) may need to be funneled to the MRC while other exams (possible PIAs) can be done at smaller facilities with guidance and support from the MRC.

The PIA may embody this hub & spoke idea all by itself. Given its ability to be completed via the internet and phone, it could very conceivably be done in a centralized fashion. Take Camp Pendleton in Southern California. It has a main MTF with multiple small BHCs spread over a base so large it can take 45 mins by car to get from the furthest two points. A potential course of action would be to base corpsmen and providers at the main MTF and they handle the PIAs for all of the satellite BHCs. Such an arrangement could benefit from

economies of scale and might be more enticing for staff; the main MTF is near one the base entrances and is much less isolated than some of the BHCs. Another potential course of action would be to scale that idea up to a regional center for PHAs, or even complete centralization of all PHAs at a single center. Despite its potential advantages, I suspect the cost would be formidable and BUMED passing on the idea of regional or enterprise-wide PHA centers.

Suitability screening could take several possible paths depending on how leadership chooses to approach its reform. Ideally readiness would be updated in near real-time. When a SM is diagnosed with anything, a provider dedicated to readiness could be alerted in the electronic medical record. The readiness provider could then make a determination the SM is fit-for-full-duty, not medically ready, or requires more information. Also likely would be centralization for the actual review of the screening. Since it is record based, no actual physical exam done, there is no reason why it could not be centralized. However, without a solid information technology backbone and real metrics, any reform is largely based on speculation. A web-based central platform for the deposit, exchange, review, and tracking of suitability screening packages has been proposed. Thus far leadership has not agreed to fund it.

Within the last two weeks, an opportunity has presented itself. A staff member who coordinates BUMED's communications & interactions with Congress called me to ask what the MRC's are. Apparently the Surgeon General of Navy had mentioned them briefly and this staff member is seeking more information. I must sheepishly confess I was surprised the most senior member would mention MRCs simply because I did not imagine he had been briefed on them; apparently someone above me has. So I may have an opportunity to present information to the Surgeon General, or one of his close staff advisors, regarding MRCs. This would be a golden chance to offer both current state and future state visions but also provide some SWOT feedback for leadership. They need to know what this project is capable of, what it might cost to achieve success, and how vulnerable it currently is. I suspect my opportunity to tell the MRC story may come in early 2017; I hope I am sufficiently prepared.

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/17/2016 9:27:12 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

Yes that makes sense

Sent from my iPhone

On Nov 17, 2016, at 1:39 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

Wont be surprised- NRA probably pushing him to and will most likely make it happen- that's why he is probably releasing this early- not knowing his fate- wants to leave some legacy

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, November 17, 2016 2:21 PM
To: Poonam Alaigh
Subject: Re: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

Dumb timing to release something- noone cares

I hear trump wants to replace him

Sent from my iPhone

On Nov 17, 2016, at 12:25 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

This is his national release of the report he was speaking to us about

From: HHS OASH Region 2 Newsletter <HHS_OASH_R2_NEWS@LIST.NIH.GOV> on behalf of (b) (6) (HHS/OASH/DRHA) (b) (6) HHS.GOV>
Sent: Thursday, November 17, 2016 11:14 AM
To: HHS_OASH_R2_NEWS@LIST.NIH.GOV
Subject: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

DATE: Thursday, November 17, 2016 at 9:00 am ET
SUBJECT: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

<image003.jpg>

OFFICE OF THE UNITED STATES SURGEON GENERAL

November 17, 2016

Today, U.S. Surgeon General Vivek H. Murthy published a landmark report on a health crisis affecting every community in our country. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* is a comprehensive review of the science of substance use, misuse, and disorders. The report is available online at Addiction.SurgeonGeneral.gov.

Nearly 21 million people in America have a substance use disorder involving alcohol or drugs, an astonishing figure that is **comparable to the number of people in our country with diabetes and higher than the total number of Americans suffering from all cancers combined**. But in spite of the massive scope of this problem, **only 1 in 10 people with a substance use disorder receives treatment**.

The societal cost of alcohol misuse is \$249 billion, and for illicit drug use it is \$193 billion. What we cannot quantify is the human toll on individuals, families, and communities affected not only by addiction, but also by alcohol and drug-related crime, violence, abuse, and child neglect.

Though this challenge is daunting, there is much reason to be hopeful. That's because we know how to solve the problem. We know that prevention works, treatment is effective, and recovery is possible for everyone. We know that we cannot incarcerate our way out of this situation; instead, we need to apply an evidence-based public health approach that brings together all sectors of our society to end this crisis. And we know that addiction is not a moral failing. It is a chronic illness that must be treated with skill, urgency, and compassion.

To mark the launch of the report, the Office of the Surgeon General and the Facing Addiction coalition are hosting "Facing Addiction in America, A National Summit." Please join the livestream of this event from the Paramount Theatre in Los Angeles at www.FacingAddiction.org today at 1 pm PST (4 pm EST). The event will feature a series of conversations with individuals affected by the crisis, experts in the field, and leaders who are making a difference.

Previous reports of the Surgeon General, including those on tobacco (1964), AIDS (1987), and mental health (1999), have helped to create understanding and urgency to address critical public health challenges. Building on this heritage, *The Surgeon General's Report on Alcohol, Drugs, and Health* will equip clinicians, policymakers, law enforcement, community leaders, and families with the evidence and tools they need to take action.

Together, we can prevent addiction and create hope for millions of people in treatment and recovery. When we stop judging, we can start helping.

To unsubscribe from the HHS_OASH_R2_NEWS list, click the following link:
http://list.nih.gov/cgi-bin/wa.exe?SUBED1=HHS_OASH_R2_NEWS&A=1

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com]
Sent: 11/17/2016 7:39:08 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

Wont be surprised- NRA probably pushing him to and will most likely make it happen- that's why he is probably releasing this early- not knowing his fate- wants to leave some legacy

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, November 17, 2016 2:21 PM
To: Poonam Alaigh
Subject: Re: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

Dumb timing to release something- noone cares

I hear trump wants to replace him

Sent from my iPhone

On Nov 17, 2016, at 12:25 PM, Poonam Alaigh [(b) (6)]@hotmail.com wrote:

This is his national release of the report he was speaking to us about

From: HHS OASH Region 2 Newsletter <HHS_OASH_R2_NEWS@LIST.NIH.GOV> on behalf of [(b) (6)] (HHS/OASH/DRHA) [(b) (6)]<HHS.GOV>
Sent: Thursday, November 17, 2016 11:14 AM
To: HHS_OASH_R2_NEWS@LIST.NIH.GOV
Subject: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

DATE: Thursday, November 17, 2016 at 9:00 am ET
SUBJECT: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

<image003.jpg>

OFFICE OF THE UNITED STATES SURGEON GENERAL

November 17, 2016

Today, U.S. Surgeon General Vivek H. Murthy published a landmark report on a health crisis affecting every community in our country. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* is a comprehensive review of the science of substance use, misuse, and disorders. The report is available online at Addiction.SurgeonGeneral.gov.

Nearly 21 million people in America have a substance use disorder involving alcohol or drugs, an astonishing figure that is **comparable to the number of people in our country with diabetes and higher than the total number of Americans suffering from all cancers combined.** But in spite of the massive scope of this problem, **only 1 in 10 people with a substance use disorder receives treatment.**

The societal cost of alcohol misuse is \$249 billion, and for illicit drug use it is \$193 billion. What we cannot quantify is the human toll on individuals, families, and communities affected not only by addiction, but also by alcohol and drug-related crime, violence, abuse, and child neglect.

Though this challenge is daunting, there is much reason to be hopeful. That's because we know how to solve the problem. We know that prevention works, treatment is effective, and recovery is possible for everyone. We know that we cannot incarcerate our way out of this situation; instead, we need to apply an evidence-based public health approach that brings together all sectors of our society to end this crisis. And we know that addiction is not a moral failing. It is a chronic illness that must be treated with skill, urgency, and compassion.

To mark the launch of the report, the Office of the Surgeon General and the Facing Addiction coalition are hosting "Facing Addiction in America, A National Summit." Please join the livestream of this event from the Paramount Theatre in Los Angeles at www.FacingAddiction.org today at 1 pm PST (4 pm EST). The event will feature a series of conversations with individuals affected by the crisis, experts in the field, and leaders who are making a difference.

Previous reports of the Surgeon General, including those on tobacco (1964), AIDS (1987), and mental health (1999), have helped to create understanding and urgency to address critical public health challenges. Building on this heritage, *The Surgeon General's Report on Alcohol, Drugs, and Health* will equip clinicians, policymakers, law enforcement, community leaders, and families with the evidence and tools they need to take action.

Together, we can prevent addiction and create hope for millions of people in treatment and recovery. When we stop judging, we can start helping.

To unsubscribe from the HHS_OASH_R2_NEWS list, click the following link:
http://list.nih.gov/cgi-bin/wa.exe?SUBED1=HHS_OASH_R2_NEWS&A=1

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/17/2016 7:21:10 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

Dumb timing to release something- noone cares

I hear trump wants to replace him

Sent from my iPhone

On Nov 17, 2016, at 12:25 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

This is his national release of the report he was speaking to us about

From: HHS OASH Region 2 Newsletter <HHS_OASH_R2_NEWS@LIST.NIH.GOV> on behalf of (b) (6) (HHS/OASH/DRHA) (b) (6) @HHS.GOV>
Sent: Thursday, November 17, 2016 11:14 AM
To: HHS_OASH_R2_NEWS@LIST.NIH.GOV
Subject: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

DATE: Thursday, November 17, 2016 at 9:00 am ET
SUBJECT: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

<image003.jpg>

OFFICE OF THE UNITED STATES SURGEON GENERAL

November 17, 2016

Today, U.S. Surgeon General Vivek H. Murthy published a landmark report on a health crisis affecting every community in our country. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* is a comprehensive review of the science of substance use, misuse, and disorders. The report is available online at Addiction.SurgeonGeneral.gov.

Nearly 21 million people in America have a substance use disorder involving alcohol or drugs, an astonishing figure that is **comparable to the number of people in our country with diabetes and higher than the total number of Americans suffering from all cancers combined**. But in spite of the massive scope of this problem, **only 1 in 10 people with a substance use disorder receives treatment**.

The societal cost of alcohol misuse is \$249 billion, and for illicit drug use it is \$193 billion. What we cannot quantify is the human toll on individuals, families, and communities affected not

only by addiction, but also by alcohol and drug-related crime, violence, abuse, and child neglect.

Though this challenge is daunting, there is much reason to be hopeful. That's because we know how to solve the problem. We know that prevention works, treatment is effective, and recovery is possible for everyone. We know that we cannot incarcerate our way out of this situation; instead, we need to apply an evidence-based public health approach that brings together all sectors of our society to end this crisis. And we know that addiction is not a moral failing. It is a chronic illness that must be treated with skill, urgency, and compassion.

To mark the launch of the report, the Office of the Surgeon General and the Facing Addiction coalition are hosting "Facing Addiction in America, A National Summit." Please join the livestream of this event from the Paramount Theatre in Los Angeles at www.FacingAddiction.org today at 1 pm PST (4 pm EST). The event will feature a series of conversations with individuals affected by the crisis, experts in the field, and leaders who are making a difference.

Previous reports of the Surgeon General, including those on tobacco (1964), AIDS (1987), and mental health (1999), have helped to create understanding and urgency to address critical public health challenges. Building on this heritage, *The Surgeon General's Report on Alcohol, Drugs, and Health* will equip clinicians, policymakers, law enforcement, community leaders, and families with the evidence and tools they need to take action.

Together, we can prevent addiction and create hope for millions of people in treatment and recovery. When we stop judging, we can start helping.

To unsubscribe from the HHS_OASH_R2_NEWS list, click the following link:
http://list.nih.gov/cgi-bin/wa.exe?SUBED1=HHS_OASH_R2_NEWS&A=1

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com
Sent: 11/17/2016 6:25:18 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

Importance: High

This is his national release of the report he was speaking to us about

From: HHS OASH Region 2 Newsletter <HHS_OASH_R2_NEWS@LIST.NIH.GOV> on behalf of [(b) (6)]
(HHS/OASH/DRHA) [(b) (6)]@HHS.GOV>
Sent: Thursday, November 17, 2016 11:14 AM
To: HHS_OASH_R2_NEWS@LIST.NIH.GOV
Subject: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health

DATE: Thursday, November 17, 2016 at 9:00 am ET
SUBJECT: Launching Today: Surgeon General's Report on Alcohol, Drugs, and Health



OFFICE OF THE UNITED STATES SURGEON GENERAL

November 17, 2016

Today, U.S. Surgeon General Vivek H. Murthy published a landmark report on a health crisis affecting every community in our country. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* is a comprehensive review of the science of substance use, misuse, and disorders. The report is available online at Addiction.SurgeonGeneral.gov.

Nearly 21 million people in America have a substance use disorder involving alcohol or drugs, an astonishing figure that is **comparable to the number of people in our country with diabetes and higher than the total number of Americans suffering from all cancers combined**. But in spite of the massive scope of this problem, **only 1 in 10 people with a substance use disorder receives treatment**.

The societal cost of alcohol misuse is \$249 billion, and for illicit drug use it is \$193 billion. What we cannot quantify is the human toll on individuals, families, and communities affected not only by addiction, but also by alcohol and drug-related crime, violence, abuse, and child neglect.

Though this challenge is daunting, there is much reason to be hopeful. That's because we know how to solve the problem. We know that prevention works, treatment is effective, and recovery is possible for everyone. We know that we cannot incarcerate our way out of this situation; instead, we need to apply an evidence-

based public health approach that brings together all sectors of our society to end this crisis. And we know that addiction is not a moral failing. It is a chronic illness that must be treated with skill, urgency, and compassion.

To mark the launch of the report, the Office of the Surgeon General and the Facing Addiction coalition are hosting “Facing Addiction in America, A National Summit.” Please join the livestream of this event from the Paramount Theatre in Los Angeles at www.FacingAddiction.org today at 1 pm PST (4 pm EST). The event will feature a series of conversations with individuals affected by the crisis, experts in the field, and leaders who are making a difference.

Previous reports of the Surgeon General, including those on tobacco (1964), AIDS (1987), and mental health (1999), have helped to create understanding and urgency to address critical public health challenges. Building on this heritage, *The Surgeon General’s Report on Alcohol, Drugs, and Health* will equip clinicians, policymakers, law enforcement, community leaders, and families with the evidence and tools they need to take action.

Together, we can prevent addiction and create hope for millions of people in treatment and recovery. When we stop judging, we can start helping.

To unsubscribe from the HHS_OASH_R2_NEWS list, click the following link:
http://list.nih.gov/cgi-bin/wa.exe?SUBED1=HHS_OASH_R2_NEWS&A=1

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/3/2016 8:12:12 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Lost her chance now

Yup done

Sent from my iPhone

On Dec 3, 2016, at 2:56 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

<http://fortune.com/2016/12/03/sarah-palin-donald-trump-carrier-deal/>



Sarah Palin Warns That Donald Trump's Carrier Deal Could Lead to 'Crony Capitalism'

fortune.com

"Let's hope every business is equally incentivized to keep Americans working in America"

Message

From: Poonam Alaigh [b] (6) [redacted]@hotmail.com]
Sent: 12/3/2016 7:56:04 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Lost her chance now

<http://fortune.com/2016/12/03/sarah-palin-donald-trump-carrier-deal/>



Sarah Palin Warns That Donald Trump's Carrier Deal Could Lead to 'Crony Capitalism'

fortune.com

"Let's hope every business is equally incentivized to keep Americans working in America"

Message

From: Poonam Alaigh [b] (6) [redacted]@hotmail.com]
Sent: 11/26/2016 3:00:38 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: This?

K- will get it sorted out- stay tuned

From: David Shulkin <drshulkin@aol.com>
Sent: Saturday, November 26, 2016 9:53 AM
To: [b] (6) [redacted]@hotmail.com
Subject: Re: This?

No not sure why it does not work

-----Original Message-----

From: Poonam Alaigh [b] (6) [redacted]@hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Nov 26, 2016 9:22 am
Subject: Fwd: This?

Let me know if this is working now

Sent from my iPad

Begin forwarded message:

From: Poonam Alaigh [b] (6) [redacted]@hotmail.com>
Date: November 26, 2016 at 9:03:57 AM EST
To: David Shulkin <drshulkin@aol.com>
Subject: This?

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/26/2016 2:53:29 PM
To: (b) (6) @hotmail.com
Subject: Re: This?

No not sure why it does not work

-----Original Message-----

From: Poonam Alaigh (b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Nov 26, 2016 9:22 am
Subject: Fwd: This?

Let me know if this is working now

Sent from my iPad

Begin forwarded message:

From: Poonam Alaigh (b) (6) @hotmail.com>
Date: November 26, 2016 at 9:03:57 AM EST
To: David Shulkin <drshulkin@aol.com>
Subject: This?

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com]
Sent: 11/26/2016 2:22:02 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: This?
Attachments: VHAOrgBrief-PresidentialTransition-DJONES_v2 (002) REVISED Access Team v7 compressed.ppt

Let me know if this is working now

Sent from my iPad

Begin forwarded message:

From: Poonam Alaigh [(b) (6)]@hotmail.com>
Date: November 26, 2016 at 9:03:57 AM EST
To: David Shulkin <drshulkin@aol.com>
Subject: This?



VA

U.S. Department
of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
 - Organization, Budget and FTEs
 - Our Mission and Who We Serve
 - Assessment of VHA's Situation
 - Priorities
 - Performance
 - Accomplishments in FY 2016
 - Future Direction, Priorities and Opportunities for VHA



Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

VA



U.S. Department
of Veterans Affairs

Organization, Budget and FTEs



Organizational Leadership

Veterans Health Administration | Leadership

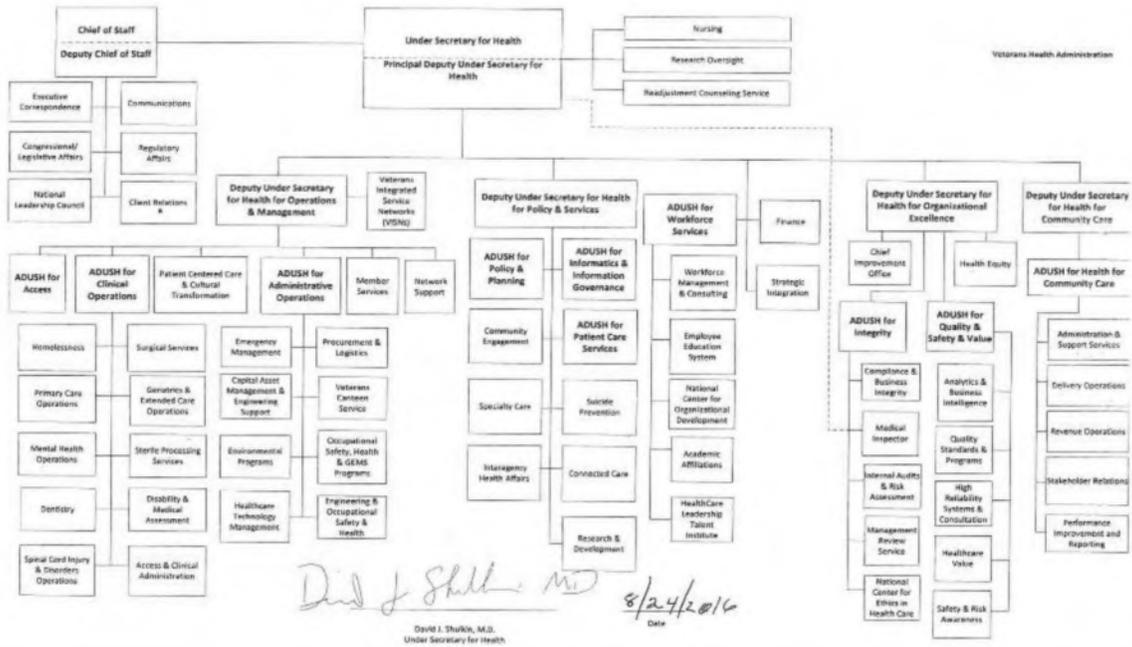
As of November 14, 2016



VA | U.S. Department of Veterans Affairs



Organization Chart



Draft / Pre-decisional / For Internal VA Use Only



U.S. Department of Veterans Affairs

Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
\$72,835,537	\$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

VA



U.S. Department
of Veterans Affairs

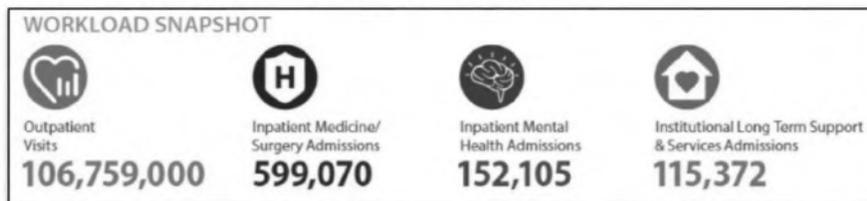
How We Are Different: Our Mission and Who We Serve



The Largest Healthcare System in the United States

- 1,234 health care facilities
 - 168 VA Medical Centers
 - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)
- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



VA



U.S. Department
of Veterans Affairs

Annual Financial Report source file for graphic

Who We Serve

- Veterans who rely most on the VA
 - Veterans with lower income
 - Veterans living in rural areas
 - Veterans without other access to health insurance coverage
 - Veterans with poorer self-reported health status
 - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

VHA's Four Missions

Overall Objective:

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Care Delivery	Develop, maintain, and operate a national health care delivery system for eligible Veterans.
Education	Administer a program of education and training for health care personnel.
Research	Conduct health care research benefitting Veterans and public
Emergency Response	Provide contingency support for Department of Defense (DOD) and Department of Health and Human Services (HHS) during times of <u>war or national emergency</u>

Our mission extends beyond healthcare for Veterans

VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

VA



U.S. Department
of Veterans Affairs

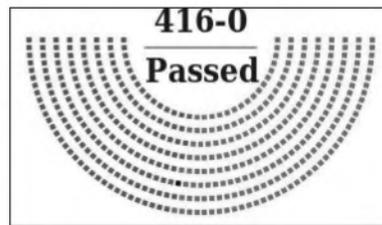
VA Healthcare Costs Not Found in the Private Sector

\$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	\$853	\$888	\$924
Camp Lejeune	\$10	\$24	\$21
Caregivers	\$454	\$623	\$725
CHAMPVA, Spina Bifida, FMP, CWVV	\$1,547	\$1,817	\$1,920
Comprehensive Emergency Medical Program	\$147	\$135	\$139
Dental Care	\$1,005	\$1,035	\$1,433
Health Professions Educational Assistance programs	\$37	\$56	\$70
Homeless Programs	\$1,507	\$1,477	\$1,591
Income Verification Match	\$17	\$19	\$19
Long Term Care	\$7,702	\$8,223	\$8,588
Readjustment Counseling	\$221	\$258	\$244
Rural Health Outreach Initiatives	\$219	\$270	\$250
Sharing Agreements - Services Provided by VA	\$157	\$157	\$166
Subtotal	\$13,875	\$14,980	\$16,090
Hepatitis C (assume 50% greater benefit)	\$406.1	\$500.0	\$500.0
Mental Health (assume 50% greater benefit)	\$2,283.9	\$2,494.9	\$2,610.6
Prosthetics (assume 50% greater benefit)	\$909.0	\$950.3	\$1,215.2
Subtotal	\$3,599.0	\$3,945.2	\$4,325.9
Total	\$17,473.9	\$18,924.9	\$20,415.8

Educational
Employment Services

20 Years of Increasing Demand for Services

- 1996 “Veterans Eligibility Reform Act”
- Conflicts in Afghanistan and Iraq continued
 - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 “The Veterans Access, Choice and Accountability Act”



- Enactment of Public Law 104-262, “Veterans Eligibility Reform Act” in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality is equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA



U.S. Department
of Veterans Affairs

Impact of VHA Research



VHA Priorities



USH 5 Priorities for Strategic Action

<p>Access</p> <p>We will provide timely access to Veterans as determined by their clinical needs.</p> <p>PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs</p>	<p>Employee Engagement</p> <p>We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.</p> <p>PSA: We will work to allow staff to have greater input into their work environment.</p>	
<p>High Performance Network</p> <p>We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.</p> <p>PSA: We will build a high performance network of care to best serve Veterans.</p>	<p>Best Practices</p> <p>We will use best clinical practices. We also seek best practices in research, education, and management.</p> <p>PSA: We seek to identify and disseminate best practices throughout VA.</p>	<p>Veterans First: Trust in VA Care</p> <p>We will be there for our Veterans when they need us.</p> <p>PSA: We will share our results on the quality and timeliness of how we care for Veterans.</p>

Priority 1: Access Transformative Changes



MyVA Access
Declaration

Prong 1

Prong 2

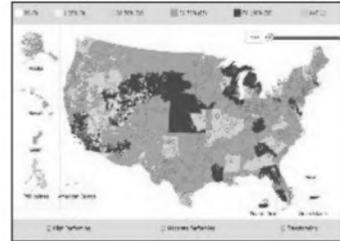
Access
Improvement
Solutions

National
Deployment
Strategy

Prong 3



*Dr. David Shulkin signing the MyVA
Declaration Statement on 4/7/2016*



Transformative changes heading

Prong

Guidebook

Map

Same day Services for urgent needs

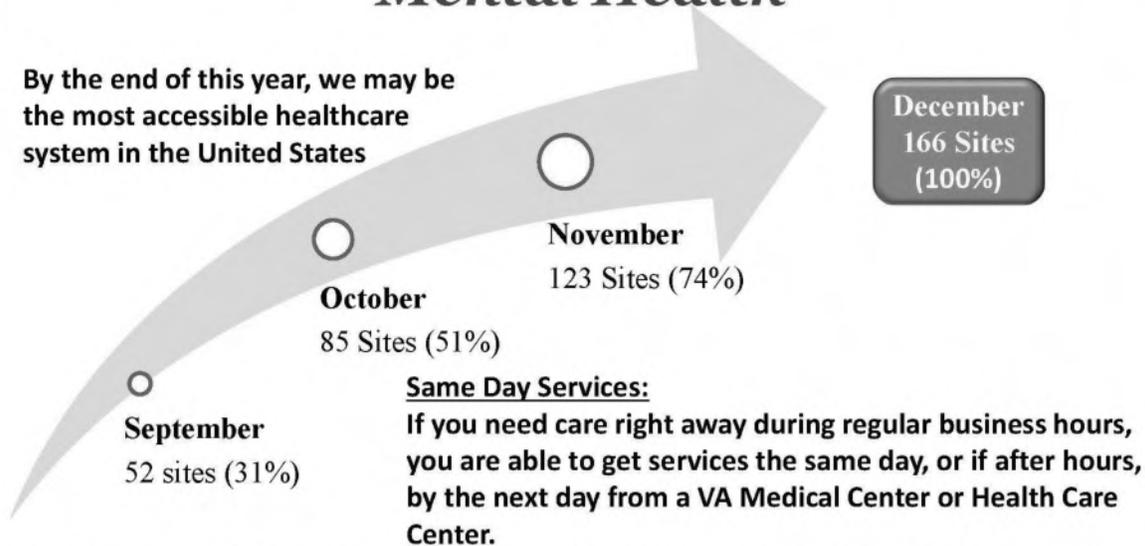
Path to SDA

Third slide is Results and impact that improve access

Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States



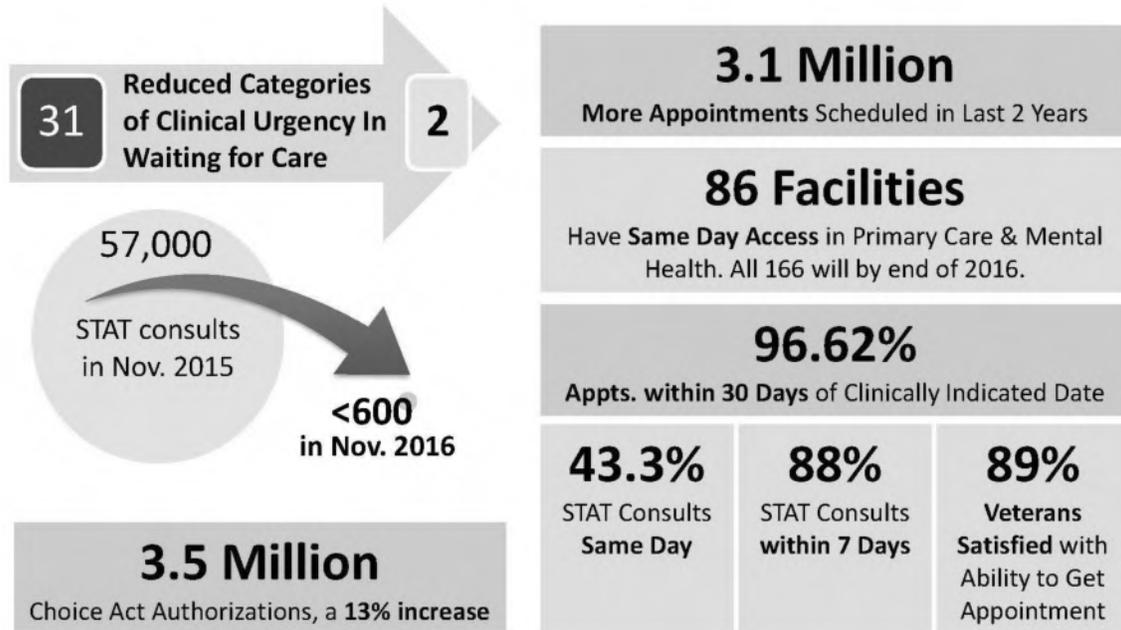
Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- For a medical emergency always call 911 or report to the emergency room closest to where you are located.

Priority 1: Access

Results that Impact Care



Draft / Pre-decisional / For Internal VA Use Only

21

VA



U.S. Department of Veterans Affairs

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)

57,000 stat consults in Nov 2015 to <600 in November 2016

3.1 Million more appointments scheduled in the last 2 years

86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016

89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)

In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date

43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)

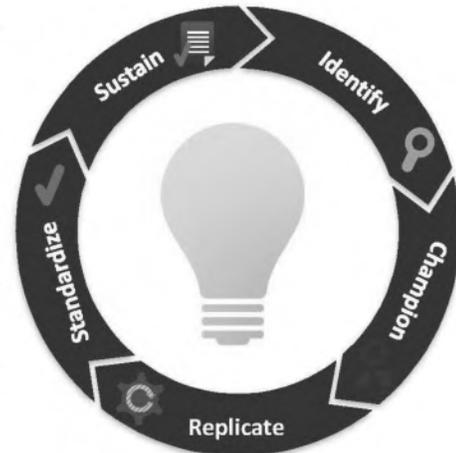
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16

Expanded scheduled hours on weekends and evenings, productivity, people, and space

More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

Priority 2: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
 - **85** of those replications have been completed **within 9 months**
 - **301** of those replication projects are **ongoing and on track**
 - **Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only

23

VA



U.S. Department
of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:

1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree	% Agree or Strongly Agree	% Agree or Strongly Agree
			Jan-Mar 2016 (Q2) (n=24,415)	Apr-Jun 2016 (Q3) (n=29,873)	Jul-Sep 2016 (Q4) (n=27,758)
VETERANS EXPERIENCE	BRAND	"I trust VA to fulfill our country's commitment to Veterans"	55%	59%	60%
	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

VHA Accomplishments in 2016



Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders

**Be there
for someone in your life.**

Connect fellow Veterans and Service members in crisis with support.

VeteransCrisisLine.net



U.S. Department
of Veterans Affairs



Veterans
Crisis Line
1-800-273-8255 PRESS 6

Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans.**
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010, **over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations:
http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

Public Health Issues

Hepatitis C Management

- In FY15 & 16, VA treated a total of **69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health



Building a Stronger Organization

- Recruited **new Principal Deputy Under Secretary for Health (PDUSH), Deputy Secretary for Health for Operations & Management (DUSHOM), 2 Assistant Deputy Under Secretary for Health (ADUSH positions), and all Deputy Under Secretary for Health (DUSH positions)**
- **8,490** new staff trained in **lean management**



5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

Serving our Veterans and the Nation

Culture of Improvement

- 6th year – VA's pharmacy benefits ranked among best in class
- 24 million in cost avoidance through our supply chain efforts
- An Integrated operations center to proactively monitor and identify issues in quality or access
- 23,000 pounds of used medications returned and destroyed this year

Service to the Nation

- 9,860 research publications in 2016
- Added 547.4 graduate medical education positions
- Responded and deployed to 6 national emergencies



VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board



1st bullet:

Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

82% of VAMCs with Improvement *SAIL Quality Measures in Past Year*

FY16Q3 SAIL Quality Star Percentile Cut-Off						
Overall Quality FY15Q4-FY16Q3 ¹	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17²	31²	55	28³	15³	146⁴

Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

VA



U.S. Department
of Veterans Affairs

Studies showing better outcomes
JAMA

Comparing VA Care to Private Sector

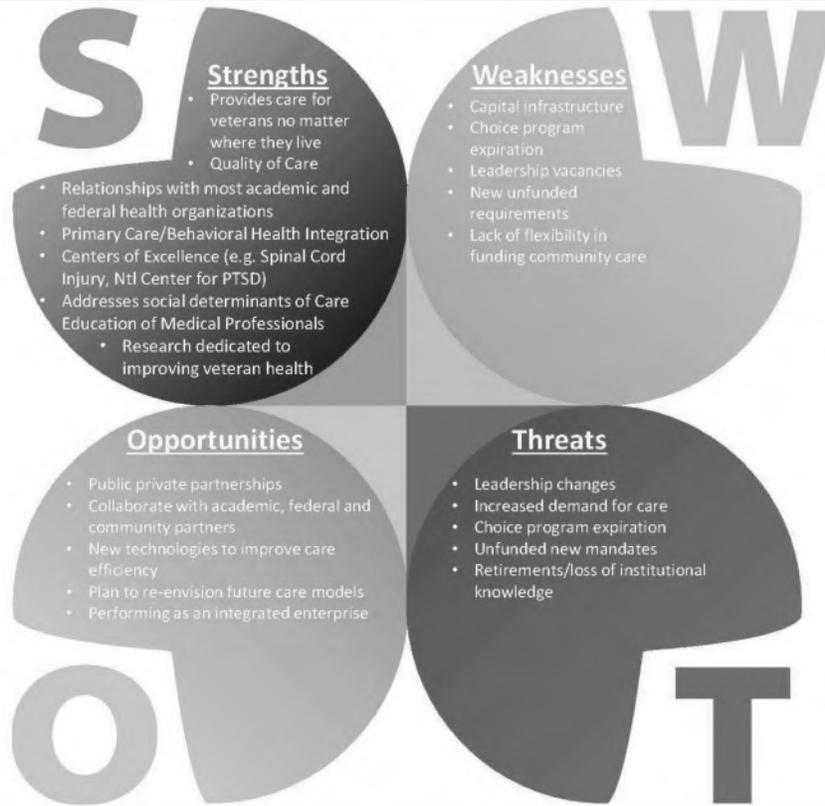
- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment



More data in press release: <http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778>

Future Direction, Priorities and Opportunities





Increasing Demand

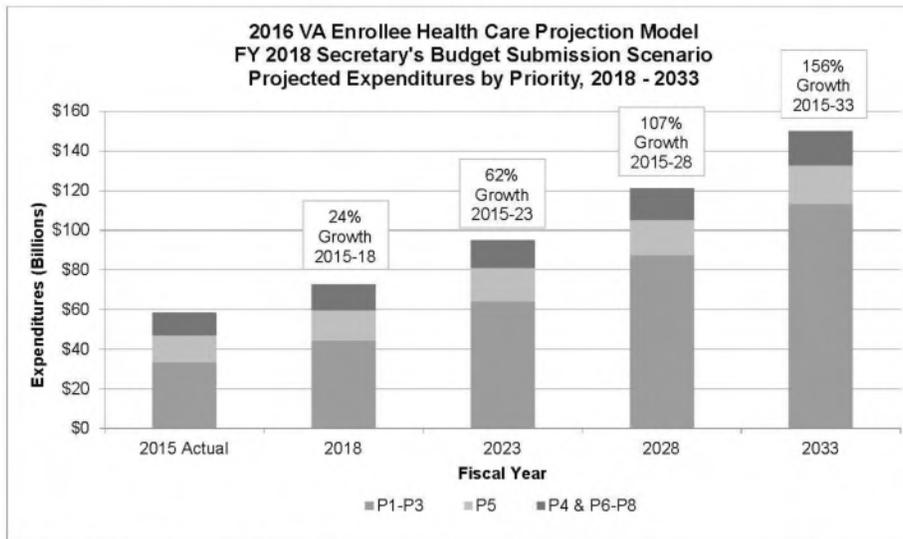
- VA completed nearly **5 million more appointments** in 2015 than in 2014 (FY 2016 data not yet available)
 - Almost **57 million appointments inside VA** and over 21 million in the community.
 - For Veterans that means **over 7 million additional hours** of care
- Veterans are aging and will need **more complex care and long term care** and support services
- Reliance on VA may grow as costs of other insurance and exchanges may increase
 - **Each 1 % increase in reliance is a cost of approximately \$1B**

3rd bullet notes:

In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

Latriece mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

VA's Resource Requirements Projected to Grow Significantly Over Time

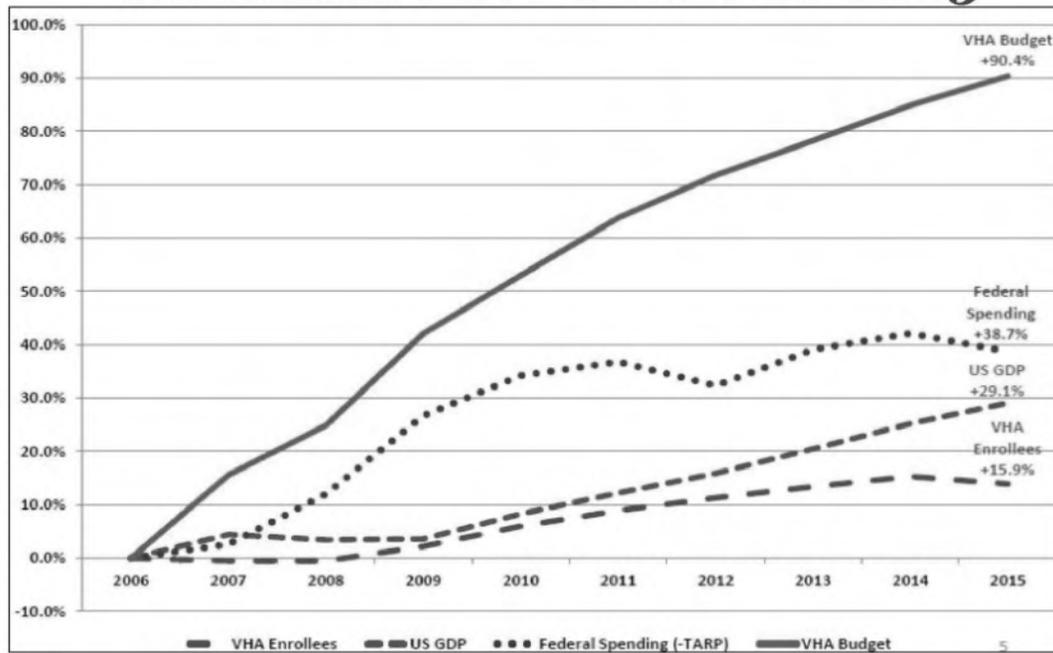


2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.



U.S. Department
of Veterans Affairs

VA Medical Care Budget Challenge: Cumulative Growth 2006-2015



2018 Budget

- VHA's FY 2018 Advance Appropriation is **\$2.8 billion less** than the total funds available in FY 2017 – a 4% decrease
- Choice Program ends 8/7/17 (**\$3.3B per year**)
- Other risks that may impact future years -These items were not included in the FY 2017 enacted budget, which includes the FY 2018 Advance Appropriations
 - \$0.5-\$1.5 Billion – Staab Court Case (Emergency Care) May generate increased future utilization \$1-\$2 Billion
 - Presumptive Service Connection – Camp Lejeune Reservists
 - In Vitro Fertilization
 - Comprehensive Addiction and Recover Act (CARA)

Bullet 3: Estimated budget numbers:

IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds

Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate

CARA = \$153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:

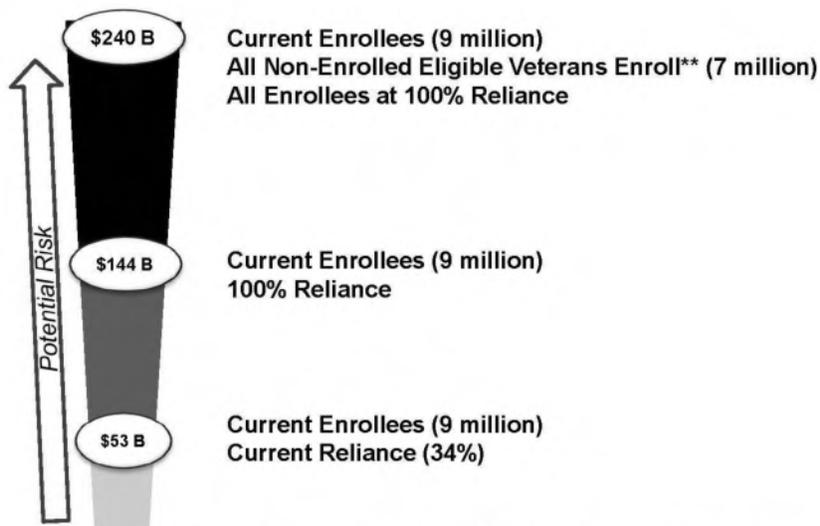
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

Potential Changes in Veteran Enrollment & Reliance on VA Health Care*



*FY 2014 actual and projected expenditures from the 2015 VA Enrollee Health Care Projection Model for modeled services: excludes readjustment counseling, Caregivers, CHAMPVA and capital expenditures.

**Note, approximately 6 million of the 22 million Veterans in 2014 were not eligible to enroll in VA health care due to income.

VA



U.S. Department
of Veterans Affairs

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was \$53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been \$144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been \$240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

Priorities for the Next Administration



Continuity of Leadership during a Crisis

Leadership vacancies and succession planning

Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust

Direction of the Commission on Care Recommendations

Supporting VHA's Course for a Future Vision

Legislative Areas of Focus

- Choice Act Authority Expires 8/7/17
- Legislative fixes to “Care in the Community”
- Critical Pay for Medical Center Directors (1A) and VISN leaders
- The 80-hour pay period
- Special pay authority for VA health care senior managers
- Budget flexibility needed

3RD BULLET:

The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

Attached for reference is the signed/dated letter from OPM regarding critical pay.

Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare



Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 11/26/2016 2:03:57 PM
To: David Shulkin [drshulkin@aol.com]
Subject: This?
Attachments: VHAOrgBrief-PresidentialTransition-DJONES v2 (002) REVISED Access Team v7 compressed.ppt



VA

U.S. Department
of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
 - Organization, Budget and FTEs
 - Our Mission and Who We Serve
 - Assessment of VHA's Situation
 - Priorities
 - Performance
 - Accomplishments in FY 2016
 - Future Direction, Priorities and Opportunities for VHA

Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

VA



U.S. Department
of Veterans Affairs

Organization, Budget and FTEs



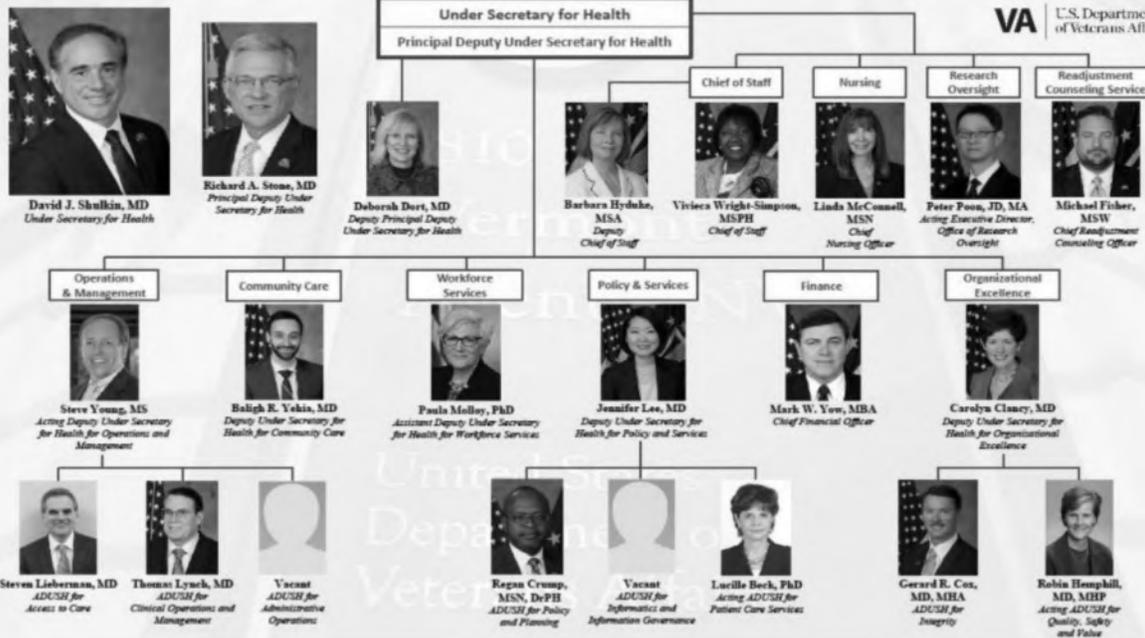
Organizational Leadership

Veterans Health Administration | Leadership

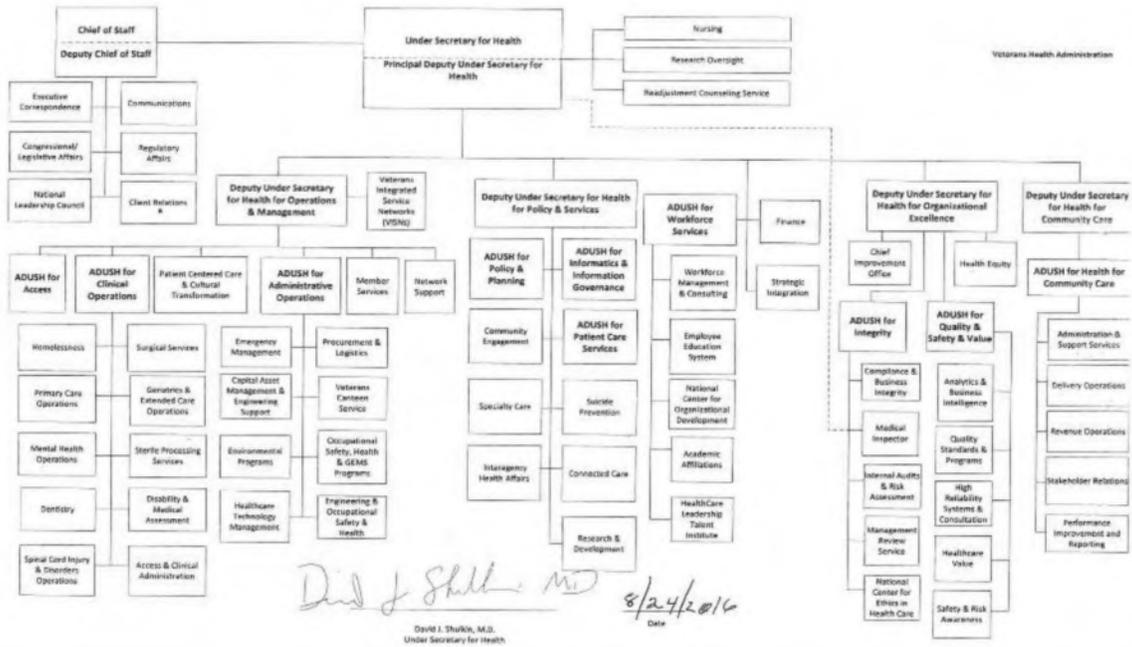
As of November 14, 2016



VA U.S. Department of Veterans Affairs



Organization Chart



Draft / Pre-decisional / For Internal VA Use Only



U.S. Department of Veterans Affairs

Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
\$72,835,537	\$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

VA



U.S. Department
of Veterans Affairs

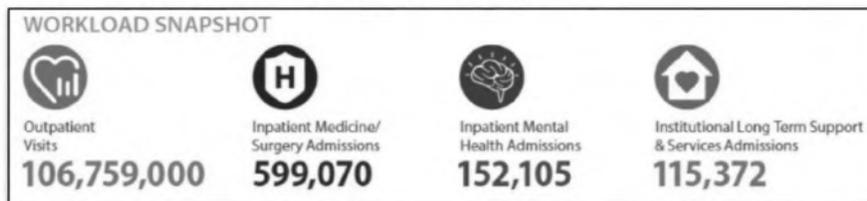
How We Are Different: Our Mission and Who We Serve



The Largest Healthcare System in the United States

- 1,234 health care facilities
 - 168 VA Medical Centers
 - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)
- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



VA



U.S. Department
of Veterans Affairs

Annual Financial Report source file for graphic

Who We Serve

- Veterans who rely most on the VA
 - Veterans with lower income
 - Veterans living in rural areas
 - Veterans without other access to health insurance coverage
 - Veterans with poorer self-reported health status
 - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

VHA's Four Missions

Overall Objective:

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Care Delivery	Develop, maintain, and operate a national health care delivery system for eligible Veterans.
Education	Administer a program of education and training for health care personnel.
Research	Conduct health care research benefitting Veterans and public
Emergency Response	Provide contingency support for Department of Defense (DOD) and Department of Health and Human Services (HHS) during times of <u>war or national emergency</u>

Our mission extends beyond healthcare for Veterans

VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

VA



U.S. Department
of Veterans Affairs

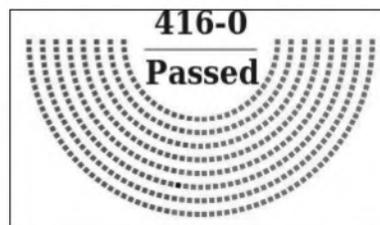
VA Healthcare Costs Not Found in the Private Sector

\$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	\$853	\$888	\$924
Camp Lejeune	\$10	\$24	\$21
Caregivers	\$454	\$623	\$725
CHAMPVA, Spina Bifida, FMP, CWVV	\$1,547	\$1,817	\$1,920
Comprehensive Emergency Medical Program	\$147	\$135	\$139
Dental Care	\$1,005	\$1,035	\$1,433
Health Professions Educational Assistance programs	\$37	\$56	\$70
Homeless Programs	\$1,507	\$1,477	\$1,591
Income Verification Match	\$17	\$19	\$19
Long Term Care	\$7,702	\$8,223	\$8,588
Readjustment Counseling	\$221	\$258	\$244
Rural Health Outreach Initiatives	\$219	\$270	\$250
Sharing Agreements - Services Provided by VA	\$157	\$157	\$166
Subtotal	\$13,875	\$14,980	\$16,090
Hepatitis C (assume 50% greater benefit)	\$406.1	\$500.0	\$500.0
Mental Health (assume 50% greater benefit)	\$2,283.9	\$2,494.9	\$2,610.6
Prosthetics (assume 50% greater benefit)	\$909.0	\$950.3	\$1,215.2
Subtotal	\$3,599.0	\$3,945.2	\$4,325.9
Total	\$17,473.9	\$18,924.9	\$20,415.8

Educational
Employment Services

20 Years of Increasing Demand for Services

- 1996 “Veterans Eligibility Reform Act”
- Conflicts in Afghanistan and Iraq continued
 - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 “The Veterans Access, Choice and Accountability Act”



- Enactment of Public Law 104-262, “Veterans Eligibility Reform Act” in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality is equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

VA



U.S. Department
of Veterans Affairs

Impact of VHA Research

VA



U.S. Department
of Veterans Affairs

VHA Priorities



USH 5 Priorities for Strategic Action

<p>Access</p> <p>We will provide timely access to Veterans as determined by their clinical needs.</p> <p>PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs</p>	<p>Employee Engagement</p> <p>We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.</p> <p>PSA: We will work to allow staff to have greater input into their work environment.</p>	
<p>High Performance Network</p> <p>We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.</p> <p>PSA: We will build a high performance network of care to best serve Veterans.</p>	<p>Best Practices</p> <p>We will use best clinical practices. We also seek best practices in research, education, and management.</p> <p>PSA: We seek to identify and disseminate best practices throughout VA.</p>	<p>Veterans First: Trust in VA Care</p> <p>We will be there for our Veterans when they need us.</p> <p>PSA: We will share our results on the quality and timeliness of how we care for Veterans.</p>

Priority 1: Access Transformative Changes



MyVA Access
Declaration

Prong 1

Prong 2

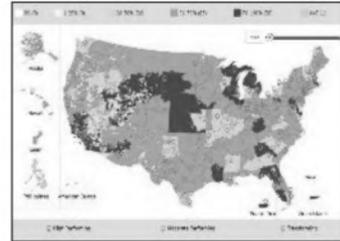
Access
Improvement
Solutions

National
Deployment
Strategy

Prong 3



*Dr. David Shulkin signing the MyVA
Declaration Statement on 4/7/2016*



19

VA



U.S. Department
of Veterans Affairs

Transformative changes heading

Prong

Guidebook

Map

Same day Services for urgent needs

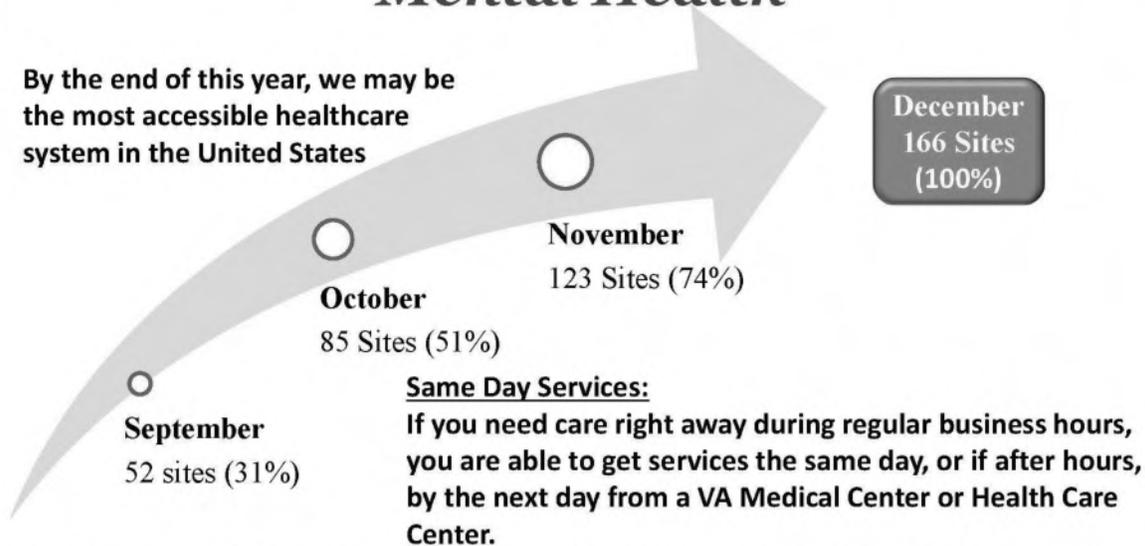
Path to SDA

Third slide is Results and impact that improve access

Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States



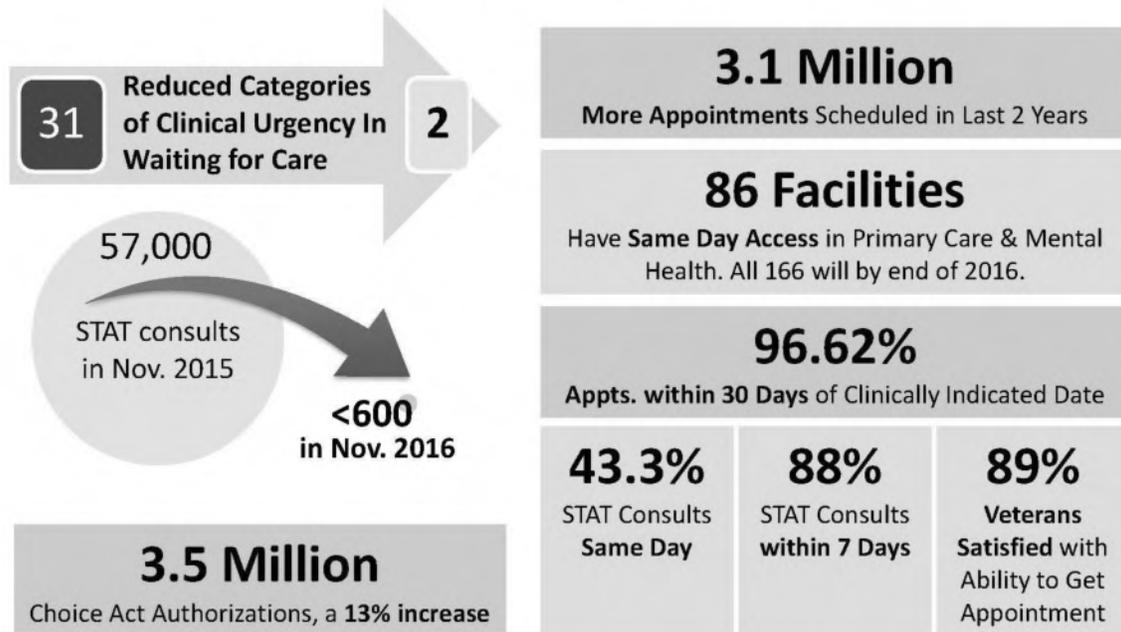
Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- For a medical emergency always call 911 or report to the emergency room closest to where you are located.

Priority 1: Access

Results that Impact Care



Draft / Pre-decisional / For Internal VA Use Only

21

VA



U.S. Department of Veterans Affairs

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)

57,000 stat consults in Nov 2015 to <600 in November 2016

3.1 Million more appointments scheduled in the last 2 years

86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016

89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)

In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date

43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)

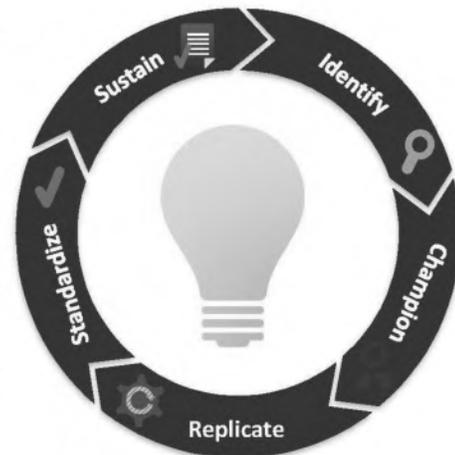
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16

Expanded scheduled hours on weekends and evenings, productivity, people, and space

More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

Priority 2: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
 - **85** of those replications have been completed **within 9 months**
 - **301** of those replication projects are **ongoing and on track**
 - **Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only

23

VA



U.S. Department
of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:

1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated (\$10 billion) was exhausted.

Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.

Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	% Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	% Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
VETERANS EXPERIENCE	BRAND	"I trust VA to fulfill our country's commitment to Veterans"	55%	59%	60%
	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

VHA Accomplishments in 2016



Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders

**Be there
for someone in your life.**

Connect fellow Veterans and Service members in crisis with support.

VeteransCrisisLine.net



U.S. Department
of Veterans Affairs



Veterans
Crisis Line
1-800-273-8255 PRESS 6

Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans.**
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010, **over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations:
http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

Public Health Issues

Hepatitis C Management

- In FY15 & 16, VA treated a total of **69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health



Building a Stronger Organization

- Recruited **new Principal Deputy Under Secretary for Health (PDUSH), Deputy Secretary for Health for Operations & Management (DUSHOM), 2 Assistant Deputy Under Secretary for Health (ADUSH positions), and all Deputy Under Secretary for Health (DUSH positions)**
- **8,490** new staff trained in **lean management**



5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

Serving our Veterans and the Nation

Culture of Improvement

- 6th year – VA's pharmacy benefits ranked among best in class
- 24 million in cost avoidance through our supply chain efforts
- An Integrated operations center to proactively monitor and identify issues in quality or access
- 23,000 pounds of used medications returned and destroyed this year

Service to the Nation

- 9,860 research publications in 2016
- Added 547.4 graduate medical education positions
- Responded and deployed to 6 national emergencies



VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board



1st bullet:

Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

82% of VAMCs with Improvement *SAIL Quality Measures in Past Year*

FY16Q3 SAIL Quality Star Percentile Cut-Off						
Overall Quality FY15Q4-FY16Q3 ¹	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17²	31²	55	28³	15³	146⁴

Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

Studies showing better outcomes
JAMA

Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

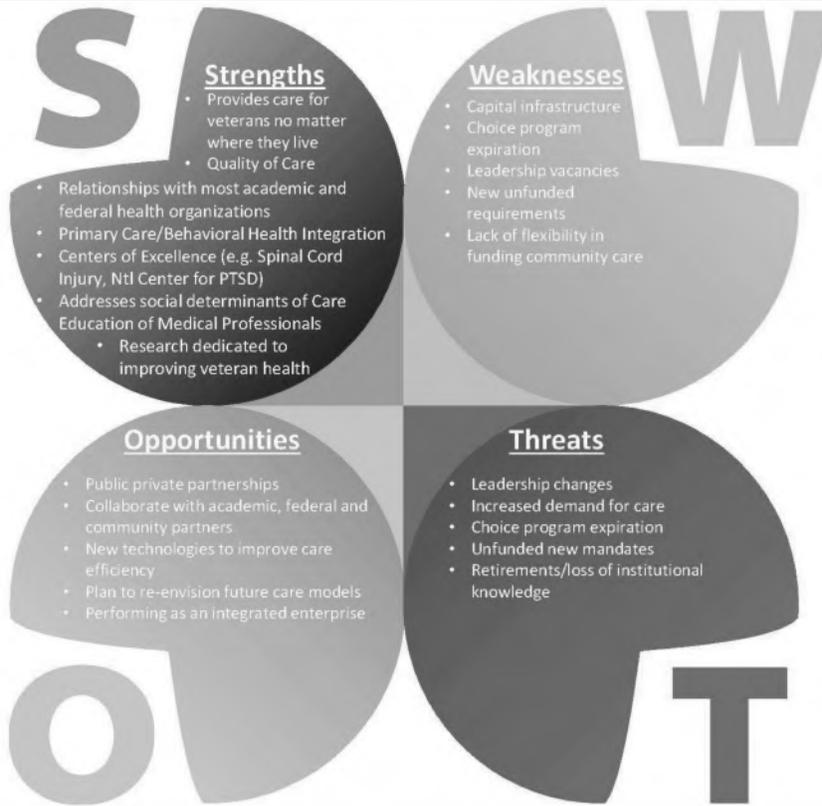


More data in press release: <http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778>

Future Direction, Priorities and Opportunities



U.S. Department
of Veterans Affairs



Increasing Demand

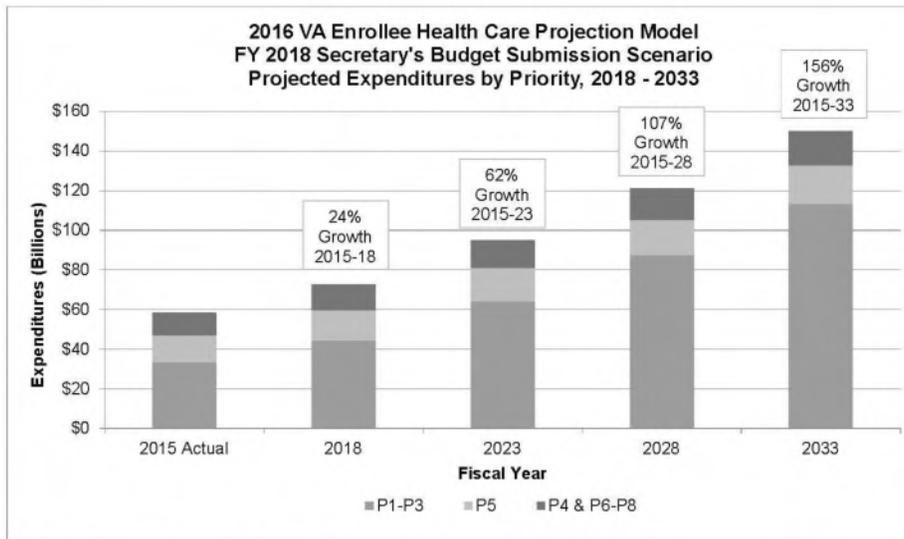
- VA completed nearly **5 million more appointments** in 2015 than in 2014 (FY 2016 data not yet available)
 - Almost **57 million appointments inside VA** and over 21 million in the community.
 - For Veterans that means **over 7 million additional hours** of care
- Veterans are aging and will need **more complex care and long term care** and support services
- Reliance on VA may grow as costs of other insurance and exchanges may increase
 - **Each 1 % increase in reliance is a cost of approximately \$1B**

3rd bullet notes:

In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

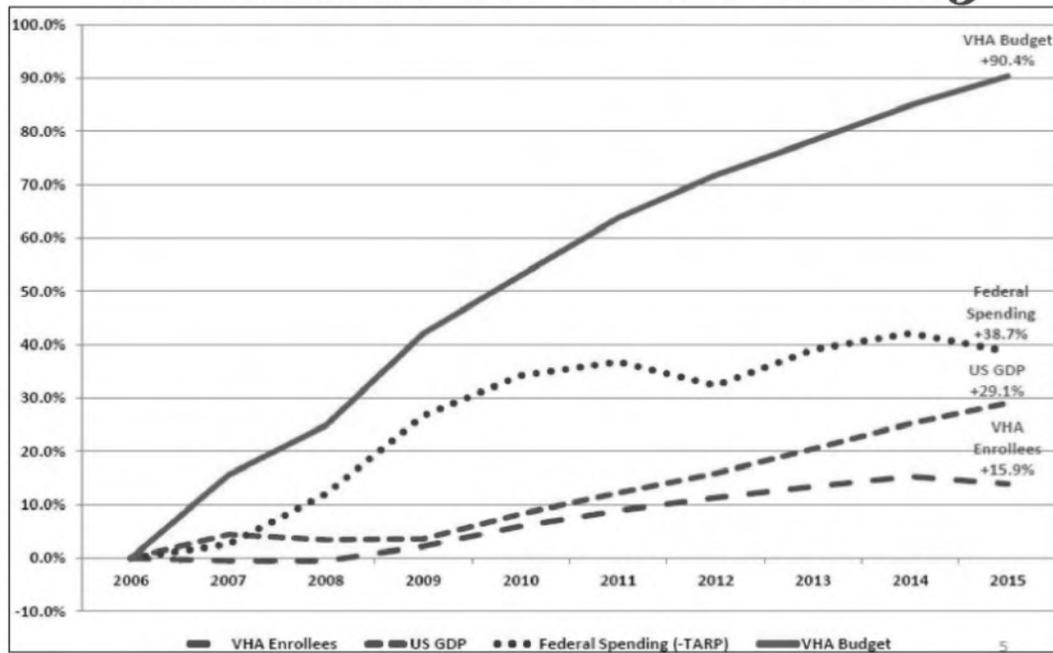
Latriece mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

VA's Resource Requirements Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

VA Medical Care Budget Challenge: Cumulative Growth 2006-2015



2018 Budget

- VHA's FY 2018 Advance Appropriation is **\$2.8 billion less** than the total funds available in FY 2017 – a 4% decrease
- Choice Program ends 8/7/17 (**\$3.3B per year**)
- Other risks that may impact future years -These items were not included in the FY 2017 enacted budget, which includes the FY 2018 Advance Appropriations
 - \$0.5-\$1.5 Billion – Staab Court Case (Emergency Care) May generate increased future utilization \$1-\$2 Billion
 - Presumptive Service Connection – Camp Lejeune Reservists
 - In Vitro Fertilization
 - Comprehensive Addiction and Recover Act (CARA)

Bullet 3: Estimated budget numbers:

IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds

Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate

CARA = \$153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:

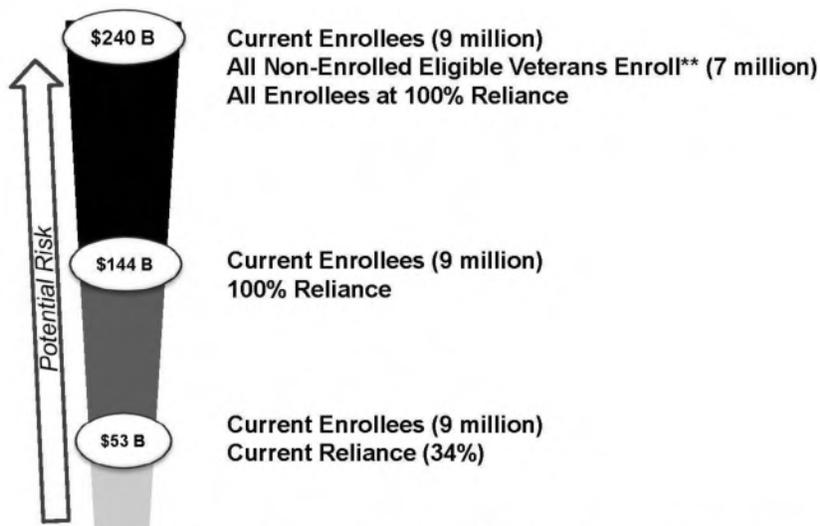
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

Potential Changes in Veteran Enrollment & Reliance on VA Health Care*



*FY 2014 actual and projected expenditures from the 2015 VA Enrollee Health Care Projection Model for modeled services: excludes readjustment counseling, Caregivers, CHAMPVA and capital expenditures.

**Note, approximately 6 million of the 22 million Veterans in 2014 were not eligible to enroll in VA health care due to income.

VA



U.S. Department of Veterans Affairs

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was \$53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been \$144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been \$240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

Priorities for the Next Administration



Continuity of Leadership during a Crisis

Leadership vacancies and succession planning

Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust

Direction of the Commission on Care Recommendations

Supporting VHA's Course for a Future Vision

Legislative Areas of Focus

- Choice Act Authority Expires 8/7/17
- Legislative fixes to “Care in the Community”
- Critical Pay for Medical Center Directors (1A) and VISN leaders
- The 80-hour pay period
- Special pay authority for VA health care senior managers
- Budget flexibility needed

3RD BULLET:

The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

Attached for reference is the signed/dated letter from OPM regarding critical pay.

Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans



A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com]
Sent: 11/10/2016 12:26:15 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: Rich Bagger

From: [(b) (6)] [(b) (6)]@yahoo.com>
Sent: Wednesday, November 9, 2016 7:04 PM
To: Poonam Alaigh
Subject: Rich Bagger

From Politico -

Health and Human Services secretary

Among the names receiving buzz: Florida Gov. Rick Scott, Gingrich and Ben Carson, a former GOP presidential candidate. Carson has received the most attention lately for HHS, even from Trump himself. At a recent anti-Obamacare rally, Trump went out of his way to praise Carson by calling him a "brilliant" physician. "I hope that he will be very much involved in my administration in the coming years," Trump said. One longer shot would be Rich Bagger, executive director of the Trump transition team and a former pharmaceutical executive who led, behind closed doors, many of the meetings this fall with health care industry donors and executives.

Thanks,

[(b) (6)]
A&T Hospitality Group

[(b) (6)]



Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 3:34:16 AM
To: Jennifer Lee [REDACTED]@gmail.com]
Subject: Re: IVF issue- can we talk tonight?

ok I'll call you

Sent from my iPad

> On Jan 11, 2017, at 2:58 PM, Jennifer Lee [REDACTED]@gmail.com> wrote:

>

> Hi David,

> Congrats again!

> I'm sure it's crazy busy right now-- but if you have a second this afternoon or this evening, I really need to talk with you about the IVF regulation issue (major concern of SVAC dems).

> We connected with Vivieca, Baligh and Steve, but I think we will need your direct intervention and help to get this done before 1/20 so it is not a sticking point.

>

> Thanks and YIPPEE!!

>

Message

From: Jennifer Lee [REDACTED]@gmail.com]
Sent: 1/11/2017 7:58:09 PM
To: David Shulkin [drshulkin@aol.com]
Subject: IVF issue- can we talk tonight?

Hi David,

Congrats again!

I'm sure it's crazy busy right now-- but if you have a second this afternoon or this evening, I really need to talk with you about the IVF regulation issue (major concern of SVAC dems).

We connected with Vivieca, Baligh and Steve, but I think we will need your direct intervention and help to get this done before 1/20 so it is not a sticking point.

Thanks and YIPPEE!!

Message

From: Jennifer Lee (b) (6) @gmail.com]
Sent: 12/3/2016 6:17:01 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

LoL! too funny!

On Dec 3, 2016 1:04 PM, "David shulkin" <Drshulkin@aol.com> wrote:

Sent from my iPhone

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/3/2016 6:04:24 PM
To: Jennifer Lee [REDACTED]@gmail.com]
Attachments: image1.jpeg

Sent from my iPhone

**TRUMP WANTS ME
TO RUN THE VA?**



**OH BOY! I LOVE
VIRGINIA!**

OCCUPY DEMOCRATS

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 10/29/2016 8:45:24 PM
To: [REDACTED]@gmail.com
Subject: SMAG
Attachments: smagnov2016.pptx

We have some work to do on smag- lets discuss at a mail call



Special Medical Advisory Committee Update November 22, 2016

David Shulkin, M.D.
Under Secretary for Health
Department of Veterans Affairs

July 31, 2016



U.S. Department
of Veterans Affairs

DAV 7/31/16

Transition Planning



VETERANS HEALTH ADMINISTRATION

2

Have We Made Progress? The Five Priorities

- Access
- Best Practices
- Employee Engagement
- High Performance Community Network
- Trust

Access

- Makes Slides from www.va.gov/accesstocare
- (use the access ones here and the choice ones for high performance network)

87 Medical Centers-Same Day Primary Care Access

Where have VERC teams deployed to?

Where are the gaps on the Road to MyVA Access?

Which solutions are VAMCs implementing?

What barriers are VAMCs currently encountering?

What is the overall implementation status at each VAMC?

MyVA Access - Service Level

Legend

- In Planning (41)
- In Progress, On Track (0)
- In Progress, Not On Track (0)
- Completed, Goal Met (0)
- Completed, Goal Not Met (0)
- Cancelled (0)
- In Sustainment (0)



VETERANS HEALTH ADMINISTRATION

Public Wait Time Data and Interactive Maps Demo

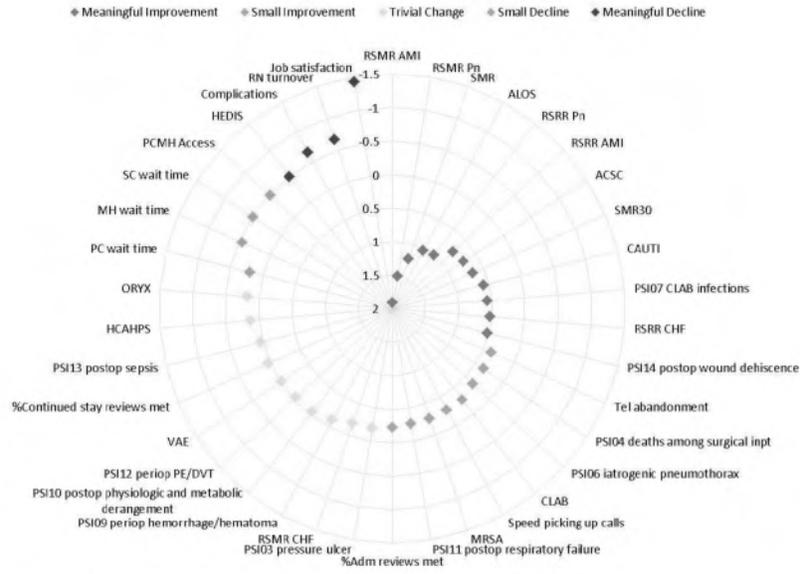
CAPH Scores- Most challenged sites

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

82% -Progress in Quality

Size of Change in Quality Indicators on SAIL Between FY2012Q2 and FY2015Q3



VETERANS HEALTH ADMINISTRATION

Diffusing Best Practices: Leverage Private Sector Practices

- ✓ **300** Internal submissions for first Under Secretary for Health (USH) Promising Practices competition
- ✓ **Over 400** Submissions to next round
- ✓ **28** Medical Center and VISN directors committed to this effort by serving as the first Shark Tank "Sharks"
- ✓ **368** ongoing replications of best practices, **70** of which are completely replicated
- ✓ **70** Sites participating in the Initiative

250+ submissions

Evaluated by VHACO SMEs in each category

40 Semi-Finalists

Evaluated by Field "Peer" SMEs

20 Finalists

Evaluated by Field leaders in "Shark Tank"

13 Gold Status

Final Gold Status selections were made by the Diffusion Council Governance Board



VETERANS HEALTH ADMINISTRATION

9

Shereef

In under **6 months**, over **260 implementations** at over **70 Facilities** across the country

Legend

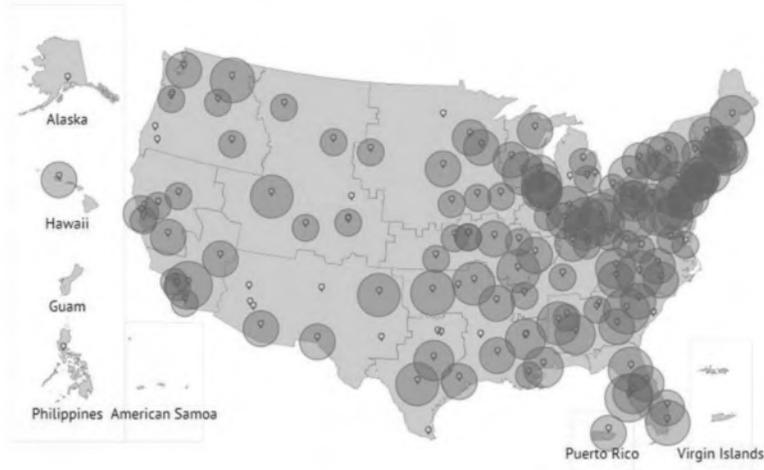


Number of Projects



VAMC or VISN Office

VHA



VETERANS HEALTH ADMINISTRATION

10

Next USH Shark Tank: November 2016

- Improving Access to Care
- Establishing Robust Care Coordination/High Performing Networks
- Increasing the Morale and Engagement of Employees
- Building Trust in VA Care/ Improving the Veteran Experience
- *Improving Quality and Safety (always a priority)*



**VHA Shark Tank Submissions
NOW OPEN!**

Specific Topics of Interest

Opioid Safety and Pain Management

Mental Health

Cancer Moonshot

Rural Veterans

OIF & OEF Veterans

Women Veterans

Kidney Disease Management

Tumor Board

Community Care Health IT Solutions

Employee Engagement

	2014	2016
"I recommend my organization as a good place to work"	3.66	3.70
Average AES Score	3.45	3.58*
		*Only year in past 10 it had been higher was 2011 when it was 2.66

TRUST

- Need to get data points from Scott Blackburn

Suicide Data- New Approaches to Prevention



VETERANS HEALTH ADMINISTRATION

- ✓ 20 Suicides per day
Increases in women and younger veterans- VHA use associated with lower rates
- ✓ Leverage partnerships to raise awareness of life-saving resources, particularly with DoD to support the transition to life after service
- ✓ Implement a data-driven approach to identify Veterans at high risk for suicide

14

On February 2, 2016, VA hosted a summit, "Preventing Veterans Suicide – A Call to Action" to bring together Veterans, families, federal agencies, community providers, subject matter experts, and other key stakeholders to enhance suicide prevention efforts.

The summit generated a new framework for VA's approach to Suicide Prevention that will transform the vision and structure of suicide prevention across VA and the community.

VA has elevated and expanded our Suicide Prevention Program to fulfill this vision, which includes:

Meeting urgent mental health needs by providing Veterans same-day evaluations and access by the end of calendar year 2016.

Building and leveraging strategic partnerships to disseminate new initiatives within VA and to reach non-VA using Veterans.

Development and implementation of innovative life-saving programs, such as REACH-VET, which uses predictive modeling to identify Veterans at high risk for suicide.

Continuing to partner with the Department of Defense for a seamless transition from military service to civilian life.

REACH VET Program



- Starts nationwide at the end of October
- Uses data to identify Veterans at high risk for suicide
- Notifies VA providers of the risk assessment

VETERANS HEALTH ADMINISTRATION

15

REACH VET uses innovative statistical methods based on VA data to identify VA-enrolled Veterans at risk for suicide and other negative outcomes.

REACH VET is a supplement to current clinical strategies of identifying patients at increased risk.

REACH VET identifies Veterans at increased risk and notifies providers of identified Veterans, so providers can reevaluate and enhance the Veteran's care.

REACH VET enhances at-risk Veterans' access to care and complements ongoing initiatives to increase access.

REACH VET starts nationwide in October 2016—it will identify thousands of Veterans with complex care needs across the country and ensure they are receiving the very best evidence-based care.

Identified At-Risk Veterans Provide Opportunities for Enhanced Care

Of those in the top **.1%**, only **30%** were identified as high risk for suicide based on clinical signs and symptoms

REACH VET Roles & Responsibilities

REACH VET Coordinators

- Organize the implementation and operations of the *REACH VET* program
- Ensure Mental Health and Primary Care Providers are aware of their responsibilities
- Ensure that notifications regarding identified patients reach the appropriate Providers

Mental Health and Primary Care Providers

- Acknowledge notification of identified at-risk patients
- Contact patients and assess them
- Reevaluate diagnoses and treatment plans
- Ensure ready access to providers when patients experience the need
- Enhance care when appropriate
 - Caring communications
 - Safety Planning

Veterans Crisis Line: After the Call



Harvey Norris
Suicide Prevention Coordinator
Alexandria, LA

VETERANS HEALTH ADMINISTRATION

18

Transformation Questions

- Are we Organized Correctly?
- What Can we Learn from the Best Systems?
- VISN's- organized around geographies?
 - Should we be organized around Centers of Excellence? Conditions? IPU's?

Value Based Resource Allocations?>

- Should VHA's internal resource systems be incented differently?

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/13/2016 5:09:47 PM
To: Poonam Alaigh (b) (6) @hotmail.com
Subject: Fwd: rich bagger is out

Sent from my iPhone

Begin forwarded

To: David shulkin <Drshulkin@aol.com>
Subject: rich bagger is out

<https://endpts.com/biotech-insider-rich-bagger-is-out-gingrich-is-up-in-latest-reshuffle-of-trumps-inner-circle/>

Message

From: Poonam Alaigh (b) (6)@hotmail.com
Sent: 12/18/2016 6:49:00 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Sounds good- think about if we need to come up with a new name for our company too

Sent from my iPhone

On Dec 18, 2016, at 1:38 PM, David Shulkin <drshulkin@aol.com> wrote:

thinking of him for our company- and collecting interim executives that might help

I was thinking that we might need to build a group of people (who are not owners but rather contractors) that we can put on our website to make us look more like a real company than a mom and pop shop.

I've started a layout for it that I will begin to work on over vacation

(b) (6), M.D., M.P.H.

(b) (6), M.D., M.P.H., joined Temple University Health System on October 13, 2008 as Vice President and Chief Medical Officer. As Vice President and Chief Medical Officer, (b) (6) responsible for providing vision and leadership for the development and implementation of quality initiatives at all Health System hospitals and facilities. This includes assuming system-wide responsibility for all patient-safety, infection control/prevention, and other key programs and initiatives that have an impact on clinical outcomes and patient-satisfaction.

(b) (6) also works to promote, in collaboration with Temple's medical faculty, increased community outreach and public-health programs and initiatives.

Prior to joining Temple, (b) (6) served as the 24th Secretary of Health for the Commonwealth of Pennsylvania. (b) (6) was appointed to this role in April 2003 by Governor Edward G. Rendell. In that capacity, (b) (6) directed the health-services and regulatory functions of Pennsylvania's Department of Health, an agency with more than 1,500 employees and a budget of nearly \$900 million, which serves Pennsylvania's 12.5 million residents.

During (b) (6) five-year tenure as Secretary, Dr. (b) (6) successfully advanced the mission and effectiveness of the Department of Health by initiating and implementing several key strategies and programs – including the allocation of more than \$350 million to research projects in the fields of vaccine development, regenerative medicine, and antibiotic resistance; increasing state funding by \$3 million for targeted HIV/AIDS prevention and early detection; and establishing a data-driven management system to improve performance management, resource allocation, and outcome measurement. Of note, in 2003, shortly after (b) (6) appointment as Secretary, (b) (6) led Pennsylvania's successful management of the largest Hepatitis A outbreak in U.S. history.

-----Original Message-----

From: Poonam Alaigh (b) (6)@hotmail.com
To: David Shulkin <drshulkin@aol.com>
Sent: Sun, Dec 18, 2016 1:31 pm
Subject: Re:

Are you thinking of something at the VA- would be good I think on many different fronts- regardless of what (b) (6) thinks. I remember you mentioned (b) (6) to me just before you started. We need to connect before you leave for 10days next week- I am working virtually this coming week. Call me tonight from the train or tomorrow when you have time so that we can give each other a status update and go over the "to-

dos"- if you get a chance- if not, I will just keep moving along and catch up once you are back

Sent from my iPhone

On Dec 18, 2016, at 1:15 PM, David Shulkin <drshulkin@aol.com> wrote:

Do you know (b) - I have known (b) for a while- (b) is desperate for work and I met with (b) today as a favor. I knew (b) at temple and (b) did not do well so I am not too impressed with (b) or (b) track record but (b) has that government background that might be helpful and (b) would be willing to be a utility player if we needed (b) for anything. I wonder what (b) (6) thinks of (b)

(b) (6), M.D., M.P.H.

(b) (6), M.D., M.P.H., joined Temple University Health System on October 13, 2008 as Vice President and Chief Medical Officer. As Vice President and Chief Medical Officer (b) (6) is responsible for providing vision and leadership for the development and implementation of quality initiatives at all Health System hospitals and facilities. This includes assuming system-wide responsibility for all patient-safety, infection control/prevention, and other key programs and initiatives that have an impact on clinical outcomes and patient-satisfaction.

(b) (6) also works to promote, in collaboration with Temple's medical faculty, increased community outreach and public-health programs and initiatives.

Prior to joining Temple, (b) (6) served as the 24th Secretary of Health for the Commonwealth of Pennsylvania. (b) (6) was appointed to this role in April 2003 by Governor Edward G. Rendell. In that capacity, (b) (6) directed the health-services and regulatory functions of Pennsylvania's Department of Health, an agency with more than 1,500 employees and a budget of nearly \$900 million, which serves Pennsylvania's 12.5 million residents.

During his five-year tenure as Secretary, Dr (b) (6) successfully advanced the mission and effectiveness of the Department of Health by initiating and implementing several key strategies and programs – including the allocation of more than \$350 million to research projects in the fields of vaccine development, regenerative medicine, and antibiotic resistance; increasing state funding by \$3 million for targeted HIV/AIDS prevention and early detection; and establishing a data-driven management system to improve performance management, resource allocation, and outcome measurement. Of note, in 2003, shortly after (b) (6) appointment as Secretary, (b) (6) led Pennsylvania's successful management of the largest Hepatitis A outbreak in U.S. history.

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/18/2016 6:38:24 PM
To: (b) (6) @hotmail.com
Subject: Re:

thinking of (b) (6) for our company- and collecting interim executives that might help

I was thinking that we might need to build a group of people (who are not owners but rather contractors) that we can put on our website to make us look more like a real company than a mom and pop shop.

I've started a layout for it that I will begin to work on over vacation

(b) (6), M.D., M.P.H.

(b) (6), M.D., M.P.H., joined Temple University Health System on October 13, 2008 as Vice President and Chief Medical Officer. As Vice President and Chief Medical Officer, (b) (6) is responsible for providing vision and leadership for the development and implementation of quality initiatives at all Health System hospitals and facilities. This includes assuming system-wide responsibility for all patient-safety, infection control/prevention, and other key programs and initiatives that have an impact on clinical outcomes and patient-satisfaction.

(b) (6) also works to promote, in collaboration with Temple's medical faculty, increased community outreach and public-health programs and initiatives.

Prior to joining Temple, (b) (6) served as the 24th Secretary of Health for the Commonwealth of Pennsylvania. (b) (6) was appointed to this role in April 2003 by Governor Edward G. Rendell. In that capacity, (b) (6) directed the health-services and regulatory functions of Pennsylvania's Department of Health, an agency with more than 1,500 employees and a budget of nearly \$900 million, which serves Pennsylvania's 12.5 million residents.

During his five-year tenure as Secretary, (b) (6) successfully advanced the mission and effectiveness of the Department of Health by initiating and implementing several key strategies and programs – including the allocation of more than \$350 million to research projects in the fields of vaccine development, regenerative medicine, and antibiotic resistance; increasing state funding by \$3 million for targeted HIV/AIDS prevention and early detection; and establishing a data-driven management system to improve performance management, resource allocation, and outcome measurement. Of note, in 2003, shortly after (b) (6) appointment as Secretary, (b) (6) led Pennsylvania's successful management of the largest Hepatitis A outbreak in U.S. history.

-----Original Message-----

From: Poonam Alaigh (b) (6) @hotmail.com
To: David Shulkin <drshulkin@aol.com>
Sent: Sun, Dec 18, 2016 1:31 pm
Subject: Re:

Are you thinking of something at the VA- would be good I think on many different fronts- regardless of what (b) (6) thinks. I remember you mentioned (b) (6) to me just before you started. We need to connect before you leave for 10days next week- I am working virtually this coming week. Call me tonight from the train or tomorrow when you have time so that we can give each other a status update and go over the "to-dos"- if you get a chance- if not, I will just keep moving along and catch up once you are back

Sent from my iPhone

On Dec 18, 2016, at 1:15 PM, David Shulkin <drshulkin@aol.com> wrote:

Do you know (b) (6) I have known (b) (6) for a while- (b) (6) is desparate for work and I met with (b) (6) today as a favor.

I knew (b) at temple and (b) did not do well so I am not too impressed with (b) or (b) track record but (b) has that government background that might be helpful and (b) would be willing to be a utility player if we needed (b) for anything. I wonder what (b) (6) thinks of (b)

(b) (6), M.D., M.P.H.

(b) (6), M.D., M.P.H., joined Temple University Health System on October 13, 2008 as Vice President and Chief Medical Officer. As Vice President and Chief Medical Officer (b) (6) is responsible for providing vision and leadership for the development and implementation of quality initiatives at all Health System hospitals and facilities. This includes assuming system-wide responsibility for all patient-safety, infection control/prevention, and other key programs and initiatives that have an impact on clinical outcomes and patient-satisfaction.

(b) (6) also works to promote, in collaboration with Temple's medical faculty, increased community outreach and public-health programs and initiatives.

Prior to joining Temple, Dr (b) (6) served as the 24th Secretary of Health for the Commonwealth of Pennsylvania. (b) was appointed to this role in April 2003 by Governor Edward G. Rendell. In that capacity, (b) (6) directed the health-services and regulatory functions of Pennsylvania's Department of Health, an agency with more than 1,500 employees and a budget of nearly \$900 million, which serves Pennsylvania's 12.5 million residents.

During his five-year tenure as Secretary, (b) (6) successfully advanced the mission and effectiveness of the Department of Health by initiating and implementing several key strategies and programs – including the allocation of more than \$350 million to research projects in the fields of vaccine development, regenerative medicine, and antibiotic resistance; increasing state funding by \$3 million for targeted HIV/AIDS prevention and early detection; and establishing a data-driven management system to improve performance management, resource allocation, and outcome measurement. Of note, in 2003, shortly after (b) appointment as Secretary, (b) (6) led Pennsylvania's successful management of the largest Hepatitis A outbreak in U.S. history.

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com
Sent: 12/18/2016 6:30:43 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Are you thinking of something at the VA- would be good I think on many different fronts- regardless of what (b) (6) thinks. I remember you mentioned (b) (6) to me just before you started. We need to connect before you leave for 10days next week- I am working virtually this coming week. Call me tonight from the train or tomorrow when you have time so that we can give each other a status update and go over the "to-dos"- if you get a chance- if not, I will just keep moving along and catch up once you are back

Sent from my iPhone

On Dec 18, 2016, at 1:15 PM, David Shulkin <drshulkin@aol.com> wrote:

Do you know (b) (6) - I have known (b) (6) for a while- (b) (6) is desparate for work and I met with (b) (6) today as a favor. I knew (b) (6) at temple and (b) (6) did not do well so I am not too impressed with (b) (6) or (b) (6) track record but (b) (6) has that government background that might be helpful and (b) (6) would be willing to be a utility player if we needed (b) (6) for anything. I wonder what (b) (6) thinks of (b) (6)

(b) (6), M.D., M.P.H.

(b) (6), M.D., M.P.H., joined Temple University Health System on October 13, 2008 as Vice President and Chief Medical Officer. As Vice President and Chief Medical Officer, (b) (6) is responsible for providing vision and leadership for the development and implementation of quality initiatives at all Health System hospitals and facilities. This includes assuming system-wide responsibility for all patient-safety, infection control/prevention, and other key programs and initiatives that have an impact on clinical outcomes and patient-satisfaction.

(b) (6) also works to promote, in collaboration with Temple's medical faculty, increased community outreach and public-health programs and initiatives.

Prior to joining Temple, (b) (6) served as the 24th Secretary of Health for the Commonwealth of Pennsylvania. (b) (6) was appointed to this role in April 2003 by Governor Edward G. Rendell. In that capacity, (b) (6) directed the health-services and regulatory functions of Pennsylvania's Department of Health, an agency with more than 1,500 employees and a budget of nearly \$900 million, which serves Pennsylvania's 12.5 million residents.

During his five-year tenure as Secretary, (b) (6) successfully advanced the mission and effectiveness of the Department of Health by initiating and implementing several key strategies and programs – including the allocation of more than \$350 million to research projects in the fields of vaccine development, regenerative medicine, and antibiotic resistance; increasing state funding by \$3 million for targeted HIV/AIDS prevention and early detection; and establishing a data-driven management system to improve performance management, resource allocation, and outcome measurement. Of note, in 2003, shortly after (b) (6) appointment as Secretary (b) (6) led Pennsylvania's successful management of the largest Hepatitis A outbreak in U.S. history.

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/18/2016 6:15:01 PM
To: (b) (6)@hotmail.com

Do you know (b) (6) - I have known (b) (6) for a while - (b) (6) is desperate for work and I met with (b) (6) today as a favor. I knew (b) (6) at temple and (b) (6) did not do well so I am not too impressed with (b) (6) or (b) (6) track record but (b) (6) has that government background that might be helpful and (b) (6) would be willing to be a utility player if we needed (b) (6) for anything. I wonder what (b) (6) thinks of (b) (6)

(b) (6), M.D., M.P.H.

(b) (6), M.D., M.P.H., joined Temple University Health System on October 13, 2008 as Vice President and Chief Medical Officer. As Vice President and Chief Medical Officer, (b) (6) is responsible for providing vision and leadership for the development and implementation of quality initiatives at all Health System hospitals and facilities. This includes assuming system-wide responsibility for all patient-safety, infection control/prevention, and other key programs and initiatives that have an impact on clinical outcomes and patient-satisfaction.

(b) (6) also works to promote, in collaboration with Temple's medical faculty, increased community outreach and public-health programs and initiatives.

Prior to joining Temple, (b) (6) served as the 24th Secretary of Health for the Commonwealth of Pennsylvania. (b) (6) was appointed to this role in April 2003 by Governor Edward G. Rendell. In that capacity (b) (6) directed the health-services and regulatory functions of Pennsylvania's Department of Health, an agency with more than 1,500 employees and a budget of nearly \$900 million, which serves Pennsylvania's 12.5 million residents.

During his five-year tenure as Secretary, (b) (6) successfully advanced the mission and effectiveness of the Department of Health by initiating and implementing several key strategies and programs – including the allocation of more than \$350 million to research projects in the fields of vaccine development, regenerative medicine, and antibiotic resistance; increasing state funding by \$3 million for targeted HIV/AIDS prevention and early detection; and establishing a data-driven management system to improve performance management, resource allocation, and outcome measurement. Of note, in 2003, shortly after (b) (6) appointment as Secretary, Dr (b) (6) led Pennsylvania's successful management of the largest Hepatitis A outbreak in U.S. history.

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 2:29:07 AM
To: (b) (6) @hotmail.com]
Subject: Fwd: POTUS Signing table

Sent from my iPhone

Begin forwarded message:

From: Robert McDonald (b) (6) @gmail.com>
Date: November 29, 2016 at 9:00:39 PM EST
To: David shulkin <Drshulkin@aol.com>
Subject: Re: POTUS Signing table

So (b) (6) is asking POTUS to sign the pic I sent with my joke on it! Good grief. Thanks.
Bob

On Tue, Nov 29, 2016 at 8:53 PM, David shulkin <Drshulkin@aol.com> wrote:
How cool!

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) RDML USN WHMO/WHMU"
(b) (6) @whmo.mil>
Date: November 29, 2016 at 8:22:18 PM EST
To: "drshulkin@aol.com" <drshulkin@aol.com>
Subject: POTUS Signing table

David,
Look what I found on the POTUS signing table. POTUS just finished his last wounded warrior visit.

(b) (6)

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 2:21:29 AM
To: Robert McDonald (b) (6) @gmail.com]
Subject: Re: POTUS Signing table

Yes my thoughts too

Sent from my iPhone

On Nov 29, 2016, at 9:00 PM, Robert McDonald (b) (6) @gmail.com> wrote:

So (b) (6) is asking POTUS to sign the pic I sent with my joke on it! Good grief. Thanks.
Bob

On Tue, Nov 29, 2016 at 8:53 PM, David shulkin <Drshulkin@aol.com> wrote:
How cool!

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) USN WHMO/WHMU"
(b) (6) @whmo.mil>
Date: November 29, 2016 at 8:22:18 PM EST
To: "drshulkin@aol.com" <drshulkin@aol.com>
Subject: POTUS Signing table

David,
Look what I found on the POTUS signing table. POTUS just finished his last
wounded warrior visit.

(b) (6)

James Jones

THE WHITE HOUSE

(b) (6)

(b) (6)

Thank you
you!

SPECIAL

RO

Message

From: Robert McDonald [(b) (6)]@gmail.com]
Sent: 11/30/2016 2:00:39 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: POTUS Signing table

So [(b) (6)] is asking POTUS to sign the pic I sent with my joke on it! Good grief. Thanks. Bob

On Tue, Nov 29, 2016 at 8:53 PM, David shulkin <Drshulkin@aol.com> wrote:
How cool!

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) USN WHMO/WHMU" [(b) (6)]@whmo.mil>
Date: November 29, 2016 at 8:22:18 PM EST
To: "drshulkin@aol.com" <drshulkin@aol.com>
Subject: POTUS Signing table

David,
Look what I found on the POTUS signing table. POTUS just finished his last wounded warrior visit.

[(b) (6)]

James Jones

THE WHITE HOUSE
(b) (6)



(b) (6) THANKS FOR LETTING DAD AND ME CATCH A RIDE BACK TO D.C. WITH YOU!
Robert C. McDaniel



THE WHITE HOUSE
(b) (6)

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/4/2016 6:33:44 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Confirmed- for drinks with Laverne on Thursday at 5:45pm

Ok

Sent from my iPhone

On Dec 4, 2016, at 1:03 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

Just got off the phone with her- its not an easy place for her right now- I think we should meet her. We are confirmed for Thursday at 5:45pm with Laverne- she will be sending out an invite. She has changed her schedule around to accommodate us. Please make a note on your calendar

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 12/4/2016 6:03:02 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Confirmed- for drinks with Laverne on Thursday at 5:45pm

Just got off the phone with her- its not an easy place for her right now- I think we should meet her. We are confirmed for Thursday at 5:45pm with Laverne- she will be sending out an invite. She has changed her schedule around to accommodate us. Please make a note on your calendar

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/29/2016 11:29:16 AM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: Transition

Ok

Sent from my iPad

On Nov 29, 2016, at 5:41 AM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

i had an extensive discussion with (b) yesterday- there is an initial draft that the will share regarding the study on Friday when we are together in Dallas- dont know what it will show but its an external validator

From: David Shulkin <drshulkin@aol.com>
Sent: Monday, November 28, 2016 9:32 PM
To: Poonam Alaigh
Subject: Fwd: Transition

Carolyn's perspectives

Sent from my iPad

Begin forwarded message:

From: Carolyn M Clancy (b) (6) @gmail.com>
Date: November 28, 2016 at 8:48:05 PM EST
To: David shulkin <drshulkin@aol.com>
Subject: Transition

Thought wiser to send from home email.

Having been through several of these I wanted to share a few thoughts. All transitions are more than a bit chaotic, with loose teams comprised of senior thought leaders 'helping out', folks who aspire to a political or other position and assorted others. Except for the 'wise men' there is a lot of jockeying for position, alliances etc -- not always easy to read. (may also be folks in VA positioning themselves).

I expect we'll see Hill staff (some will needs join very soon) from the majority side and maybe folks from think tanks (I'm keeping my ears open since I know a few from the Bush administration).

I see 2 big challenges:

The first is after initial polite conversation -- do they buy anything we are telling them? To that end external validators could be useful (though can't assume that entities we think of as household names, e.g. TJC, NAM) are known quantities.

The second has made me anxious since coming to VA: a combination of limited political insight and a 'DoD' view of the world. No matter what challenges DoD commands a level of respect rarely accorded VA, and we have a large # at the Dept, that it may distort their perceptions.

So I think you are right that we are likely far more effective telling our own story.

Please know you can count on my full support.

Carolyn

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com
Sent: 11/29/2016 10:41:38 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Transition

i had an extensive discussion with [(b) (6)] yesterday- there is an initial draft that the will share regarding the study on Friday when we are together in Dallas- dont know what it will show but its an external validator

From: David Shulkin <drshulkin@aol.com>
Sent: Monday, November 28, 2016 9:32 PM
To: Poonam Alaigh
Subject: Fwd: Transition

Carolyn's perspectives

Sent from my iPad

Begin forwarded message:

From: Carolyn M Clancy [(b) (6)]@gmail.com>
Date: November 28, 2016 at 8:48:05 PM EST
To: David shulkin <drshulkin@aol.com>
Subject: Transition

Thought wiser to send from home email.

Having been through several of these I wanted to share a few thoughts. All transitions are more than a bit chaotic, with loose teams comprised of senior thought leaders 'helping out', folks who aspire to a political or other position and assorted others. Except for the 'wise men' there is a lot of jockeying for position, alliances etc -- not always easy to read. (may also be folks in VA positioning themselves).

I expect we'll see Hill staff (some will needs join very soon) from the majority side and maybe folks from think tanks (I'm keeping my ears open since I know a few from the Bush administration).

I see 2 big challenges:

The first is after initial polite conversation -- do they buy anything we are telling them? To that end external validators could be useful (though can't assume that entities we think of as household names, e.g. TJC, NAM) are known quantities.

The second has made me anxious since coming to VA: a combination of limited political insight and a 'DoD' view of the world. No matter what challenges DoD commands a level of respect rarely accorded VA, and we have a large # at the Dept, that it may distort their perceptions.

So I think you are right that we are likely far more effective telling our own story.

Please know you can count on my full support.

Carolyn

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/29/2016 2:54:54 AM
To: (b) (6) [redacted]@hotmail.com]
Subject: Fwd: Transition

Sent from my iPad

Begin forwarded message:

From: Carolyn M Clancy (b) (6) [redacted]@gmail.com>
Date: November 28, 2016 at 8:48:05 PM EST
To: David shulkin <drshulkin@aol.com>
Subject: Transition

Thought wiser to send from home email.

Having been through several of these I wanted to share a few thoughts. All transitions are more than a bit chaotic, with loose teams comprised of senior thought leaders 'helping out', folks who aspire to a political or other position and assorted others. Except for the 'wise men' there is a lot of jockeying for position, alliances etc -- not always easy to read. (may also be folks in VA positioning themselves).

I expect we'll see Hill staff (some will needs join very soon) from the majority side and maybe folks from think tanks (I'm keeping my ears open since I know a few from the Bush administration).

I see 2 big challenges:

The first is after initial polite conversation -- do they buy anything we are telling them? To that end external validators could be useful (though can't assume that entities we think of as household names, e.g. TJC, NAM) are known quantities.

The second has made me anxious since coming to VA: a combination of limited political insight and a 'DoD' view of the world. No matter what challenges DoD commands a level of respect rarely accorded VA, and we have a large # at the Dept, that it may distort their perceptions.

So I think you are right that we are likely far more effective telling our own story.

Please know you can count on my full support.

Carolyn

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/29/2016 2:32:51 AM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Fwd: Transition

Carolyn's perspectives

Sent from my iPad

Begin forwarded message:

From: Carolyn M Clancy (b) (6) @gmail.com>
Date: November 28, 2016 at 8:48:05 PM EST
To: David shulkin <drshulkin@aol.com>
Subject: Transition

Thought wiser to send from home email.

Having been through several of these I wanted to share a few thoughts. All transitions are more than a bit chaotic, with loose teams comprised of senior thought leaders 'helping out', folks who aspire to a political or other position and assorted others. Except for the 'wise men' there is a lot of jockeying for position, alliances etc -- not always easy to read. (may also be folks in VA positioning themselves).

I expect we'll see Hill staff (some will needs join very soon) from the majority side and maybe folks from think tanks (I'm keeping my ears open since I know a few from the Bush administration).

I see 2 big challenges:

The first is after initial polite conversation -- do they buy anything we are telling them? To that end external validators could be useful (though can't assume that entities we think of as household names, e.g. TJC, NAM) are known quantities.

The second has made me anxious since coming to VA: a combination of limited political insight and a 'DoD' view of the world. No matter what challenges DoD commands a level of respect rarely accorded VA, and we have a large # at the Dept, that it may distort their perceptions.

So I think you are right that we are likely far more effective telling our own story.

Please know you can count on my full support.

Carolyn

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/29/2016 2:32:24 AM
To: Carolyn M Clancy [REDACTED]@gmail.com]
Subject: Re: Transition

Thanks Carolyn- very good insights

I have similar views-

At the very least it will be entertaining like the rest of this crazy election was

Sent from my iPad

> On Nov 28, 2016, at 8:48 PM, Carolyn M Clancy [REDACTED]@gmail.com> wrote:

>
> Thought wiser to send from home email.
>
> Having been through several of these I wanted to share a few thoughts. All transitions are more than a bit chaotic, with loose teams comprised of senior thought leaders 'helping out', folks who aspire to a political or other position and assorted others. Except for the 'wise men' there is a lot of jockeying for position, alliances etc -- not always easy to read. (may also be folks in VA positioning themselves).
>
> I expect we'll see Hill staff (some will needs join very soon) from the majority side and maybe folks from think tanks (I'm keeping my ears open since I know a few from the Bush administration).
>
> I see 2 big challenges:
>
> The first is after initial polite conversation -- do they buy anything we are telling them? To that end external validators could be useful (though can't assume that entities we think of as household names, e.g. TJC, NAM) are known quantities.
>
> The second has made me anxious since coming to VA: a combination of limited political insight and a 'DoD' view of the world. No matter what challenges DoD commands a level of respect rarely accorded VA, and we have a large # at the Dept, that it may distort their perceptions.
>
> So I think you are right that we are likely far more effective telling our own story.
>
> Please know you can count on my full support.
>
> Carolyn

Message

From: Carolyn M Clancy [REDACTED]@gmail.com]
Sent: 11/29/2016 1:48:05 AM
To: David shulkin [drshulkin@aol.com]
Subject: Transition

Thought wiser to send from home email.

Having been through several of these I wanted to share a few thoughts. All transitions are more than a bit chaotic, with loose teams comprised of senior thought leaders 'helping out', folks who aspire to a political or other position and assorted others. Except for the 'wise men' there is a lot of jockeying for position, alliances etc -- not always easy to read. (may also be folks in VA positioning themselves).

I expect we'll see Hill staff (some will needs join very soon) from the majority side and maybe folks from think tanks (I'm keeping my ears open since I know a few from the Bush administration).

I see 2 big challenges:

The first is after initial polite conversation -- do they buy anything we are telling them? To that end external validators could be useful (though can't assume that entities we think of as household names, e.g. TJC, NAM) are known quantities.

The second has made me anxious since coming to VA: a combination of limited political insight and a 'DoD' view of the world. No matter what challenges DoD commands a level of respect rarely accorded VA, and we have a large # at the Dept, that it may distort their perceptions.

So I think you are right that we are likely far more effective telling our own story.

Please know you can count on my full support.

Carolyn

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/28/2016 2:32:49 AM
To: Poonam Alaigh [REDACTED]@hotmail.com]
Subject: Re:

K

Sent from my iPhone

> On Nov 27, 2016, at 9:32 PM, Poonam Alaigh [REDACTED]@hotmail.com> wrote:

>

> Btw- is it dinner or afternoon time- I want both!!

>

> Sent from my iPhone

>

>> On Nov 27, 2016, at 9:26 PM, Poonam Alaigh [REDACTED]@hotmail.com> wrote:

>>

>> Great- it's a dinner date then. Also, will stop by in the afternoon if you still have time and maybe we can grab coffee- meeting [REDACTED], [REDACTED] introduced me to for lunch. Need to fill you in on all that

>>

>> Sent from my iPhone

>>

>>> On Nov 27, 2016, at 9:22 PM, David shulkin <Drshulkin@aol.com> wrote:

>>>

>>> Dont know your schedule tomorrow but we can get together at dinner or im relatively free between 1230 and 3 due to some cancellations

>>>

>>> Sent from my iPhone

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 11/28/2016 2:32:05 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Btw- is it dinner or afternoon time- I want both!!

Sent from my iPhone

> On Nov 27, 2016, at 9:26 PM, Poonam Alaigh [REDACTED]@hotmail.com> wrote:

>

> Great- it's a dinner date then. Also, will stop by in the afternoon if you still have time and maybe we can grab coffee- meeting [REDACTED] introduced me to for lunch. Need to fill you in on all that

>

> Sent from my iPhone

>

>> On Nov 27, 2016, at 9:22 PM, David shulkin <Drshulkin@aol.com> wrote:

>>

>> Dont know your schedule tomorrow but we can get together at dinner or im relatively free between 1230 and 3 due to some cancellations

>>

>> Sent from my iPhone

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/28/2016 2:22:19 AM
To: Poonam Alaigh [REDACTED@hotmail.com]

Dont know your schedule tommorow but we can get together at dinner or im relatively free between 1230 and 3 due to some cancellations

Sent from my iPhone

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/13/2017 12:48:33 AM
To: [REDACTED] mac.com
Subject: Re: Committee for the VA

excellent- thanks

-----Original Message-----

From: Bruce Moskowitz <[REDACTED] mac.com>
To: [REDACTED] @ccf.org>; [REDACTED] M.D., M.D. [REDACTED] @mayo.edu>; [REDACTED] [REDACTED] @jhmi.edu>; [REDACTED] @partners.org>; [REDACTED] [REDACTED] @mayo.edu>; [REDACTED] <[REDACTED] gmail.com>; IP <[REDACTED] @frenchangel59.com>; David shulkin <drshulkin@aol.com>
Cc: Marisol Garcia <[REDACTED] @marvel.com>
Sent: Thu, Jan 12, 2017 6:37 pm
Subject: Committee for the VA

We need to have a meeting as soon as possible with David Shulkin please give me some convenient times. We plan to develop a working agenda. Thank you.

Sent from my iPhone

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/13/2017 12:47:36 AM
To: (b) (6) @gmail.com
Subject: Fwd: Committee for the VA

lets discuss in am and please print out for me

-----Original Message-----

From: Marc Sherman [(b) (6) @gmail.com]
To: Bruce Moskowitz <(b) (6) @mac.com>
Cc: (b) (6) <(b) (6) @ccf.org>; (b) (6) M.D., M.D. (b) (6) @mayo.edu; (b) (6) @jhmi.edu; (b) (6) (b) (6) @partners.org; (b) (6) (b) (6) @mayo.edu; IP (b) (6) @frenchangel59.com; David shulkin <drshulkin@aol.com>; Marisol Garcia <mgarcia@marvel.com>
Sent: Thu, Jan 12, 2017 7:10 pm
Subject: Re: Committee for the VA

Sunday - After 2pm
Monday - All day
Wednesday - 8am - 10am
Friday 9am-10-30am

On Thu, Jan 12, 2017 at 6:36 PM, Bruce Moskowitz <(b) (6) @mac.com> wrote:

We need to have a meeting as soon as possible with David Shulkin please give me some convenient times. We plan to develop a working agenda. Thank you.

Sent from my iPhone

Message

From: Marc Sherman [(b) (6)]@gmail.com]
Sent: 1/13/2017 12:10:00 AM
To: Bruce Moskowitz [(b) (6)]@mac.com]
CC: [(b) (6)]@ccf.org; [(b) (6)] M.D. [(b) (6)]@mayo.edu; [(b) (6)] [(b) (6)]@jhmi.edu; [(b) (6)]@partners.org; [(b) (6)] [(b) (6)]@mayo.edu; IP [(b) (6)]@frenchangel59.com; David shulkin [drshulkin@aol.com]; Marisol Garcia [(b) (6)]@marvel.com]
Subject: Re: Committee for the VA

Sunday - After 2pm
Monday - All day
Wednesday - 8am - 10am
Friday 9am-10-30am

On Thu, Jan 12, 2017 at 6:36 PM, Bruce Moskowitz <[(b) (6)]@mac.com> wrote:

We need to have a meeting as soon as possible with David Shulkin please give me some convenient times. We plan to develop a working agenda. Thank you.

Sent from my iPhone

Message

From: Bruce Moskowitz [REDACTED@mac.com]
Sent: 1/12/2017 11:36:54 PM
To: [REDACTED]@ccf.org; [REDACTED] M.D. [REDACTED]@mayo.edu; [REDACTED]@jhmi.edu; [REDACTED]@partners.org; [REDACTED] [REDACTED]@mayo.edu; mbs [REDACTED]@gmail.com; IP [REDACTED]@frenchangel59.com]; David shulkin [drshulkin@aol.com]
CC: Marisol Garcia [REDACTED]@marvel.com
Subject: Committee for the VA

We need to have a meeting as soon as possible with David Shulkin please give me some convenient times. We plan to develop a working agenda. Thank you.

Sent from my iPhone

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/26/2016 3:58:56 PM
To: [REDACTED]@hotmail.com

unfortunately none of these open for me. I can open on my phone but not any of my computers
It must be that I have old powerpoint software that does not recognize the newer version.
I don't know if anyone on your team can save in an older powerpoint format or not.
If not I will do it on Monday at the office- which will work

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 1:42:40 AM
To: Jennifer Lee (b) (6) @gmail.com]
Subject: Fwd: H.R. 5600 No Hero Left Untreated Act

Sent from my iPhone

Begin forwarded message:

From: (b) (6) (b) (6) @me.com>
Date: December 4, 2016 at 8:35:15 PM EST
To: David Shulkin <Drshulkin@aol.com>
Subject: H.R. 5600 No Hero Left Untreated Act

The H.R. 5600 "No Hero Left Untreated Act" passed through the House with a unanimous vote last week on 11/29/16!! The bill still needs to pass through the Senate, but this is a tremendously important milestone.

The link below is to C-Span coverage for the day, the relevant clip begins at 2:19:00 with the actual vote occurring at 2:27:34 <https://www.c-span.org/video/?419236-102/us-house-legislative-business&live&vod>

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 10/23/2016 6:55:10 PM
To: [REDACTED]@gmail.com
Subject: amsus presentation on nov 30th
Attachments: amsusnov30th.pptx

I also have this saved on the ironkey in case that is easier



AMSUS

Twenty-Five Quick Ways VA is Leading American Health Care

David Shulkin, M.D.
Under Secretary for Health
Department of Veterans Affairs

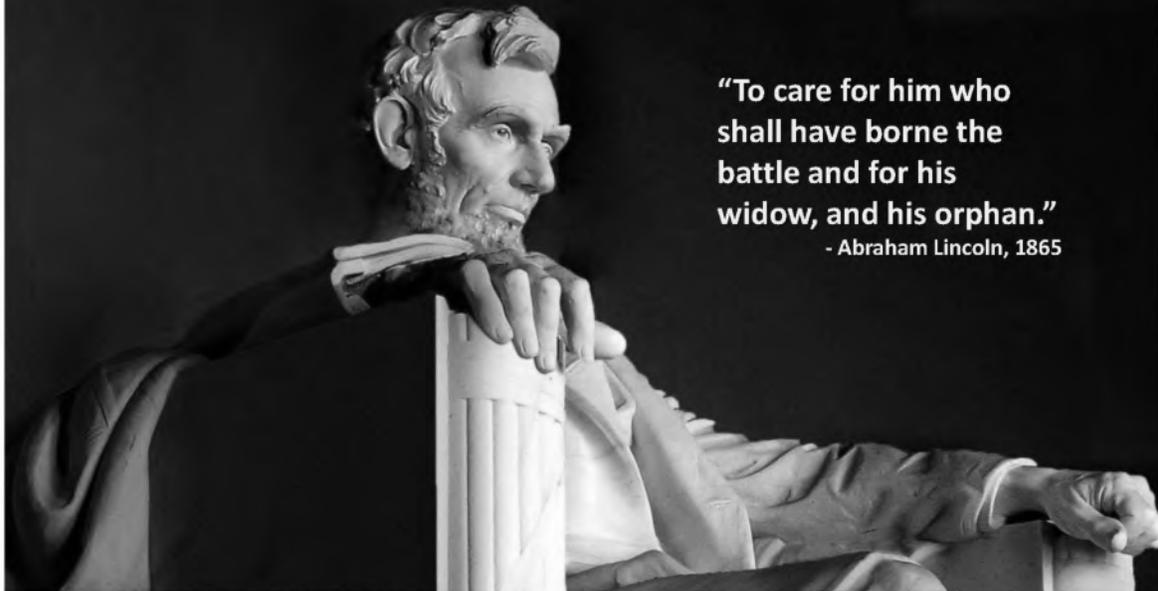
July 20, 2016



U.S. Department
of Veterans Affairs

VVA 7/20/16

#1: Best Mission and Patients in the World



**"To care for him who
shall have borne the
battle and for his
widow, and his orphan."**

- Abraham Lincoln, 1865

VETERANS HEALTH ADMINISTRATION

2

Our Mission In Their Own Words



VETERANS HEALTH ADMINISTRATION

3

#2: VA's Definition of Health

	Private Sector	Veterans Health Administration
Peer Support		X
Crisis Lines		X
Transportation		X
Caregivers		X
Homelessness Services		X
Medication Support		X
Behavioral Health Integration		X
Aligned Incentives		X
Lifelong Relationships		X
Single EMR Platform		X
Works with Most Leading Medical Centers		X
Vocational Support		X

Restoring Health on a Mountain or a Wall



VETERANS HEALTH ADMINISTRATION



#3: Outcomes of Care Performance vs. Private Sector

MEASURE	PRIVATE SECTOR	VA
Mortality Rates		XX
Common Process Measures		XX
Patient Safety		XX
Pharmacy Benefit		XX



VETERANS HEALTH ADMINISTRATION



6

#4: Leading in Public Health Issues

HEPATITIS C
→



VETERANS HEALTH ADMINISTRATION

7

National Message to Veterans



VETERANS HEALTH ADMINISTRATION

8

#5: Centers of Excellence

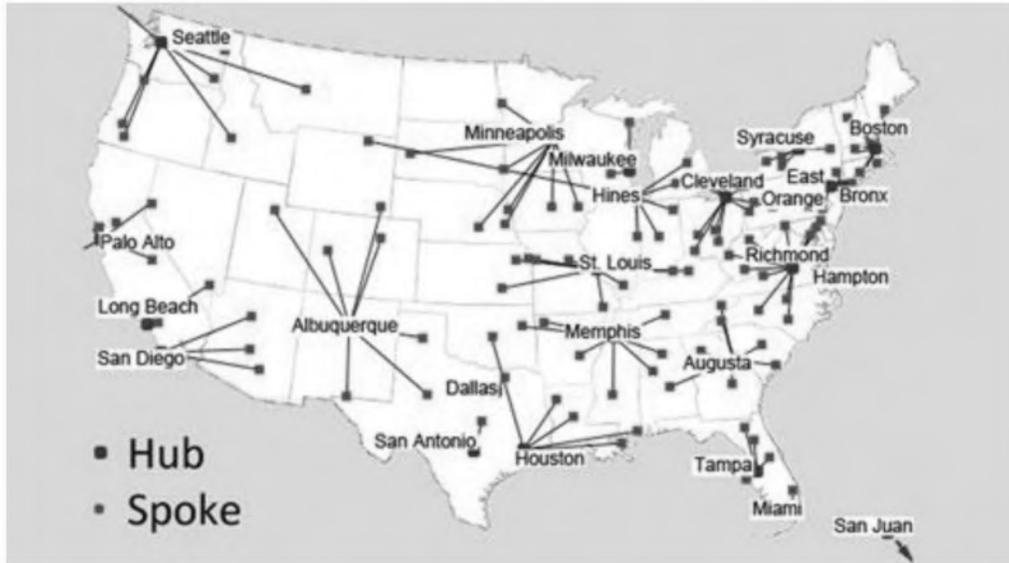
PolyTrauma Care System



VETERANS HEALTH ADMINISTRATION



Treatment of Spinal Cord Injury



VETERANS HEALTH ADMINISTRATION

10

#6: Approach to Team-Based Care



VETERANS HEALTH ADMINISTRATION

11

#7: Commitment to Access

*my***VA**Access
Declaration

We aspire to provide access to care
based on the following core principles:

- ★ Provide timely care, including same day services in Primary Care, as needed
- ★ Provide timely Mental Health care, including same day services, as needed
- ★ Provide Veterans medically necessary care from another VA Medical Center, while away from their primary facility
- ★ Respond to routine clinical inquiries within 2 business days
- ★ Offer appointments and other follow-up options upon leaving clinic
- ★ Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances
- ★ Integrate community providers as appropriate to enhance access
- ★ Offer Veterans extended clinic hours, and/or virtual care options, such as Telehealth, when appropriate
- ★ Transparently report access to care data to Veterans and the public

We the undersigned dedicate ourselves to pursuing the above principles:

 U.S. Department
of Veterans Affairs 

VETERANS HEALTH ADMINISTRATION

12

Same Day Access

>100 VA Medical Centers
now provide same day
access to care ...

... and all will by
December 31, 2016

**#YOUR
VACARE
NOW**



#8: Telehealth Services

2.14 million episodes to 677,000 Veterans (12%)



Home Telehealth
156,000 Veterans



Video Telehealth
282,000 Veterans



**Store-and-Forward
Telehealth**
298,000 Veterans

45% of our Telehealth services are for rural Veterans

336,000 TeleMental health visits

VETERANS HEALTH ADMINISTRATION

14

Home Telehealth (HT) – Care and case management of chronic conditions and provision of non-institutional care support to patients. Uses in-home and mobile technologies to manage diabetes, chronic heart failure, hypertension, obesity, traumatic brain injury, depression, etc.

Clinical Video Telehealth (CVT) – Real-time video consultation that covers more than 45 clinical specialties, including: TeleIntensive Care, TeleMental Health, TeleCardiology, TeleNeurology, TeleSurgery, Women's Telehealth, Tele-Primary Care, TeleSCI/D, TeleAmputation, TeleAudiology, TeleSpeech, Remote Nursing Home Consultation, TelePathology, etc.
Store-and-Forward Telehealth (SFT) – TeleRetinal Imaging, TeleDermatology, TeleWound Care, TeleSpirometry, Tele-Sleep Studies

#9- Use of Predictive Analytics REACH VET Program



- Started nationwide at the end of October
- Uses data to identify Veterans at high risk for suicide
- Notifies VA providers of the risk assessment

VETERANS HEALTH ADMINISTRATION

15

REACH VET uses innovative statistical methods based on VA data to identify VA-enrolled Veterans at risk for suicide and other negative outcomes.

REACH VET is a supplement to current clinical strategies of identifying patients at increased risk.

REACH VET identifies Veterans at increased risk and notifies providers of identified Veterans, so providers can reevaluate and enhance the Veteran's care.

REACH VET enhances at-risk Veterans' access to care and complements ongoing initiatives to increase access.

REACH VET starts nationwide in October 2016—it will identify thousands of Veterans with complex care needs across the country and ensure they are receiving the very best evidence-based care.

The Predictive Model

- Developed by VA, NIMH, and university-based researchers
- Includes clinical and administrative data for each Veteran who utilizes VHA health care services

Calculated Risk

Outcome	Top .1% Top Risk
Suicide (one month)	33 x
Suicide (one year)	15 x
Suicide attempt (one year)	81 x

**As compared to overall VHA population*

#10: Progress in Reducing Homelessness



VETERANS HEALTH ADMINISTRATION

17

#11: A Leader in Innovation

Technology | Tue Mar 8, 2016 12:36pm EST

Related: SCIENCE, TECH

The World's Most Innovative Research Institutions

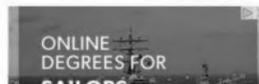
BY DAVID EWALT



Our top photos from the last 24 hours. [Slideshow »](#)

[Trump rally mayhem](#)

[A refugee childhood](#)



VETERANS HEALTH ADMINISTRATION



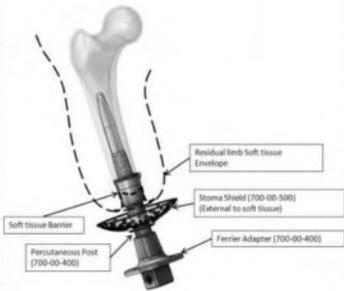
U.S. DEPARTMENT OF VETERANS AFFAIRS
CENTER FOR INNOVATION

18

Osseointegration



Bryant Jacobs, 35, Herriman, Utah
Specialist, U.S. Army
2003-2006



Ed Salau, 45, Stella, N.C.
First Lieutenant, N.C. Army National Guard
1988-2000 (Marines)
2000-2005 (NC Army Nat'l Guard)



VETERANS HEALTH ADMINISTRATION

Mobile Hearing Aid App: Veterans Can Get Their Hearing Aid Adjusted Without Ever Leaving Home

The Mobile Hearing Aid App leverages smartphones and Bluetooth technology so that an audiology technician can adjust hearing aids for Veterans remotely wherever the Veteran is located



VETERANS HEALTH ADMINISTRATION

Top Sources of Value	
 Veteran Value	<ul style="list-style-type: none"> • On-demand care model: Service is delivered when and where the Veteran needs it • Increases access to audiology care and reduces travel costs and time • Increases access for Veterans by expanding care to a population that otherwise may not have chosen to receive hearing aid adjustments
 Operational Value	<ul style="list-style-type: none"> • This technology allows audiology technicians to perform hearing aid adjustments, freeing up audiologists to focus on Veterans requiring more skilled care • Reduces the costs associated with performing hearing aid adjustments by moving the provider from a traditional brick-and-mortar facility to a centralized location with lower overhead costs

Innovation Coordinator: Allison Amrhein | Lead Innovator: Chad Gladden | Location: Cleveland VAMC

20

Center for Compassionate Innovation @ VA

To enhance Veterans' health and well-being by offering safe and ethical therapies after traditional treatments have not been successful



VETERANS HEALTH ADMINISTRATION



U.S. Department
of Veterans Affairs

#12: Health Professional Education



VETERANS HEALTH ADMINISTRATION

22

Education and Training



VETERANS HEALTH ADMINISTRATION

- VA partners with more than **1,800** educational institutions and organizations
- VA trains:
 - **62,000** medical students and residents
 - **23,000** nursing students
 - **33,000** students in other health fields
- An estimated **70%** of all U.S. doctors have trained with VA

23

We're affiliated with many of the best medical schools and training programs—more than 1,800 educational institutions.

We train 120,000 health care professionals a year, more than any system in the nation:

62,000 medical students and residents

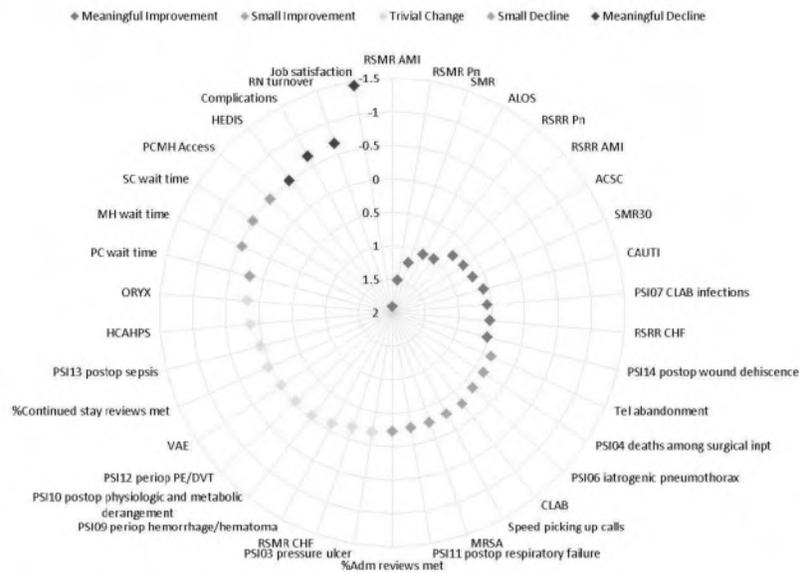
23,000 nursing students

33,000 students in other health fields.

An estimated 70% of all U.S. doctors have trained with VA, and we're the largest employer of nurses in the nation.

#13: Analytics in Health Care

Size of Change in Quality Indicators on SAIL Between FY2012Q2 and FY2015Q3



VETERANS HEALTH ADMINISTRATION

Tracking Outcomes Inside and Outside VA



VETERANS HEALTH ADMINISTRATION

25

#14: Prosthetics and Orthotics



VETERANS HEALTH ADMINISTRATION

26

#15: Toxic Exposures



VETERANS HEALTH ADMINISTRATION

27

#16: Genomics Program

DISCOVERY — INNOVATION — ADVANCEMENT

MVP

**Million Veteran Program:
A Partnership
with Veterans**

 Veterans Health Administration
Research & Development
Improving Veterans' Lives — www.research.va.gov



VETERANS HEALTH ADMINISTRATION

29

#17: Centers for Simulation



VETERANS HEALTH ADMINISTRATION

30

#18: VA Research is Essential for America



First Liver Transplant



CT Scanner



Artificial Kidney



7 Lasker Awards



3 Nobel Prizes

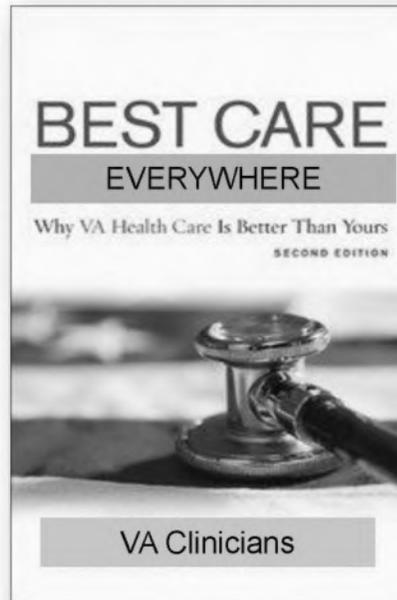
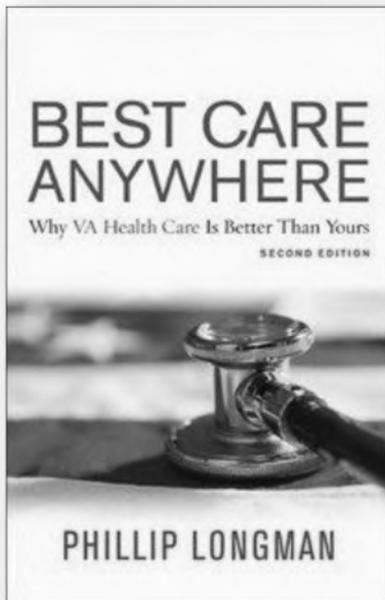


Nicotine Patches

Cardiac Pacemaker

VETERANS HEALTH ADMINISTRATION

#19: Acting as an Integrated Enterprise



VETERANS HEALTH ADMINISTRATION

32

#20: VA's Fourth Mission

Federal Coordinating Centers



VETERANS HEALTH ADMINISTRATION

33

#21: Behavioral Health Integration

VA Primary Care- Mental Health Integration (PC-MHI)



U.S. Department
of Veterans Affairs



Primary Care-Mental Health Integration
Joining Physical & Mental Health for Veterans



#22: Electronic Medical Record

Screenshot of VistA EMR

The screenshot displays the VistA EMR interface for patient MARDL F F. The main window shows a list of lab results for Hematology. Below the table is a line graph showing the trend of Hemoglobin (Hgb) over time.

Date/Time	Specimen	WBC	HGB	HCT	PLT	RBC
06/19/00 09:00	Blood	11.1	11.4	37.6	73	
07/01/00 09:00	Blood	11.6	11.6	38.4	75	6.1
07/05/00 09:00	Blood	11.6	11.6	38.4	75	6.1
08/07/00 09:00	Blood	11.1	11.1	36.9	73	6.1
08/16/00 09:00	Blood	11.6	11.6	38.4	75	6.1
08/25/00 09:00	Blood	10.8	10.8	36.9	73	6.1
08/31/00 09:00	Blood	10.7	10.7	36.9	73	6.1
09/13/00 09:00	Blood	10.7	10.7	36.9	73	6.1
09/13/00 09:00	Blood	25.7	5.4	16.9	28.1	6.1
09/20/00 09:00	Blood	29.4	10.1	30.7	21.6	6.1

The line graph plots Hemoglobin (Hgb) values over time, showing a general downward trend from approximately 11.4 in June 2000 to 5.4 in September 2000. The graph includes a legend for 'Hgb (Blood)' and a key for 'Abnormal Low', 'Abnormal High', 'Critical Value', and 'Comment on Specimen'.

VETERANS HEALTH ADMINISTRATION

35

#23: Vet Centers

Vet
Center

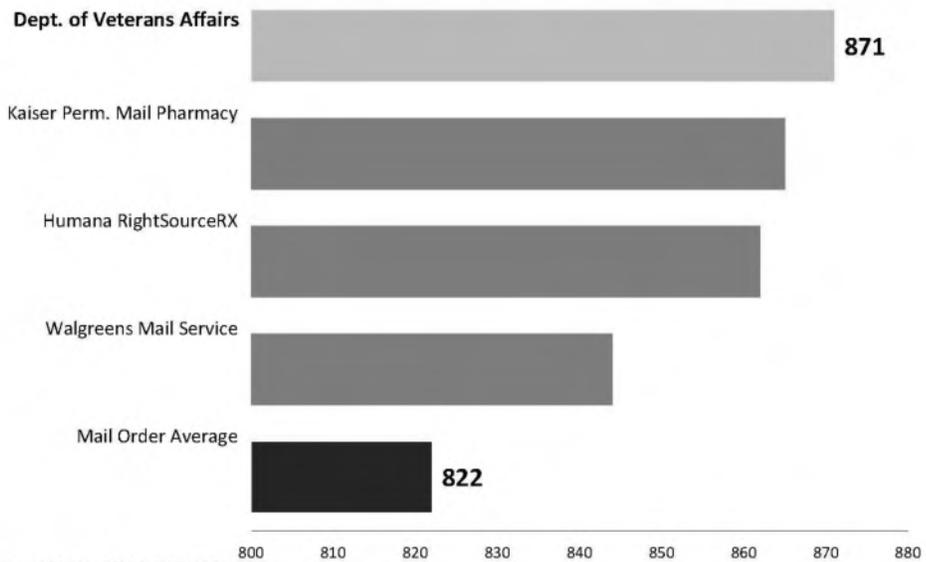


VETERANS HEALTH ADMINISTRATION

36

#24: Pharmacy Management

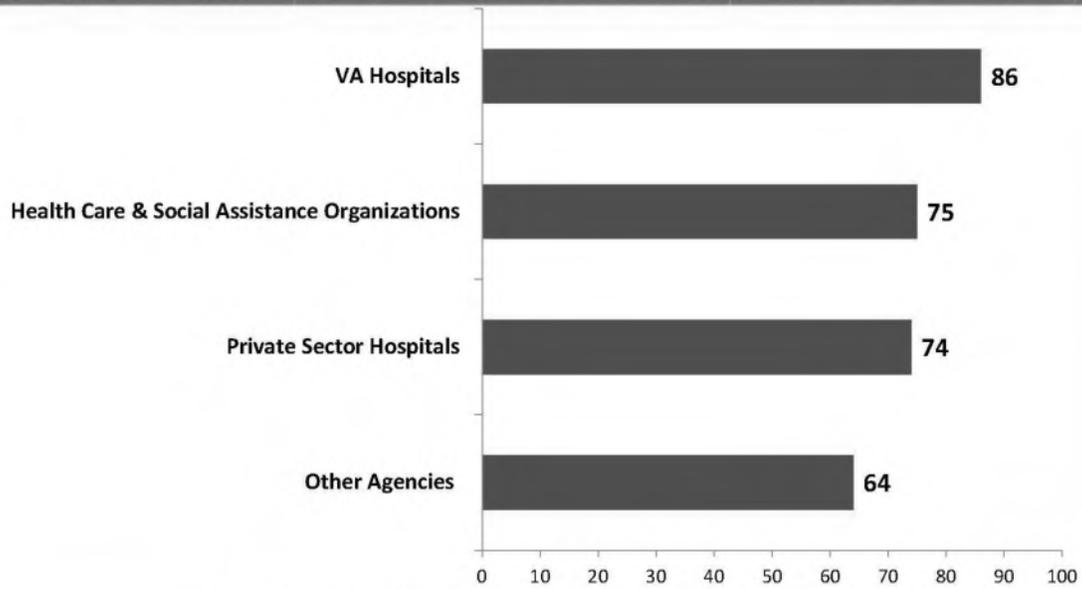
J.D. Power's Mail Order Pharmacy Overall Satisfaction



VETERANS HEALTH ADMINISTRATION

37

ASCI Loyalty Survey Overall Satisfaction



91% of Veterans feel positive about their VA Medical Center

VETERANS HEALTH ADMINISTRATION

38

#25: Partnering to Serve Veterans



Strategic Partnerships

Veterans Day Parade

<https://www.youtube.com/watch?v=38pl8hc9aso&feature=youtu.be>

Comments?



VETERANS HEALTH ADMINISTRATION

41

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com]
Sent: 12/5/2016 1:27:34 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] PRIMO Keynote Address

The next tour has to be internally focused most certainly vs the external focus on Access etc this past tour

Sent from my iPhone

On Dec 5, 2016, at 8:16 AM, David shulkin <Drshulkin@aol.com> wrote:

If i extend my tour im going to fix our issues here

Sent from my iPhone

On Dec 5, 2016, at 7:35 AM, Poonam Alaigh [(b) (6)]@hotmail.com> wrote:

Sounds great- you should go most definitely, but don't know the hurdles that come my way though

Sent from my iPhone

On Dec 5, 2016, at 7:32 AM, David shulkin <Drshulkin@aol.com> wrote:

Maui in february?

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD"
<David.Shulkin@va.gov>
Date: December 5, 2016 at 7:04:22 AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
Subject: FW: [EXTERNAL] PRIMO Keynote Address

-----Original Message-----

From: [(b) (6)]
[(b) (6)]@cancerexpertnow.com]
Sent: Sunday, December 04, 2016 08:13 PM
Eastern Standard Time
To: Shulkin, David J., MD
Cc: [(b) (6)]
Subject: [EXTERNAL] PRIMO Keynote Address

Hi Dr. Shulkin,

It was a sincere pleasure to meet you on Friday in Dallas. I admired and enjoyed your message on partnership and collaboration!

It that spirit of partnership and collaboration it is my honor to invite you, on behalf of our meeting Co-Chairs; (b) (6) and (b) (6) to give the Keynote Address at the PRIMO meeting (February 9-12, 2017 in Maui). The meeting will have some of the world's top Cancer experts present recent data on immuno and molecular oncology across a variety of tumor types. I will be happy to send you or your team any information you need. You can also find some of the details at www.primomeeting.org.

We hope you are both interested and available to attend and look forward to hearing back.

Best,

(b) (6)

(b) (6)

(b) (6)

(m) (b) (6)

www.cancerexpertnow.com

<image001.png> (b) (6)

<image002.png><image003.png>

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com]
Sent: 12/5/2016 1:25:40 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] PRIMO Keynote Address

Agree- for Rich to go around you to Sloan on Friday is unacceptable - amongst the many other issues

Sent from my iPhone

On Dec 5, 2016, at 8:16 AM, David shulkin <Drshulkin@aol.com> wrote:

If i extend my tour im going to fix our issues here

Sent from my iPhone

On Dec 5, 2016, at 7:35 AM, Poonam Alaigh [(b) (6)]@hotmail.com> wrote:

Sounds great- you should go most definitely, but don't know the hurdles that come my way though

Sent from my iPhone

On Dec 5, 2016, at 7:32 AM, David shulkin <Drshulkin@aol.com> wrote:

Maui in february?

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD"
<David.Shulkin@va.gov>
Date: December 5, 2016 at 7:04:22 AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
Subject: FW: [EXTERNAL] PRIMO Keynote Address

-----Original Message-----

From: [(b) (6)]
[(b) (6)]@cancerexpertnow.com]
Sent: Sunday, December 04, 2016 08:13 PM
Eastern Standard Time
To: Shulkin, David J., MD
Cc: [(b) (6)]
Subject: [EXTERNAL] PRIMO Keynote Address

Hi Dr. Shulkin,

It was a sincere pleasure to meet you on Friday in Dallas. I admired and enjoyed your message on partnership and collaboration!

In that spirit of partnership and collaboration it is my honor to invite you, on behalf of our meeting Co-Chairs; (b) (6) to give the Keynote Address at the PRIMO meeting (February 9-12, 2017 in Maui). The meeting will have some of the world's top Cancer experts present recent data on immuno and molecular oncology across a variety of tumor types. I will be happy to send you or your team any information you need. You can also find some of the details at www.primomeeting.org.

We hope you are both interested and available to attend and look forward to hearing back.

Best,

(b) (6)

(b) (6)

(m) (b) (6)

www.cancerexpertnow.com

<image001.png> (b) (6)

<image002.png><image003.png>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 1:16:45 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: [EXTERNAL] PRIMO Keynote Address

If i extend my tour im going to fix our issues here

Sent from my iPhone

On Dec 5, 2016, at 7:35 AM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

Sounds great- you should go most definitely, but don't know the hurdles that come my way though

Sent from my iPhone

On Dec 5, 2016, at 7:32 AM, David shulkin <Drshulkin@aol.com> wrote:

Maui in february?

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: December 5, 2016 at 7:04:22 AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
Subject: FW: [EXTERNAL] PRIMO Keynote Address

-----Original Message-----

From: (b) (6) (b) (6) @cancerexpertnow.com]
Sent: Sunday, December 04, 2016 08:13 PM Eastern Standard Time
To: Shulkin, David J., MD
Cc: (b) (6)
Subject: [EXTERNAL] PRIMO Keynote Address

Hi Dr. Shulkin,

It was a sincere pleasure to meet you on Friday in Dallas. I admired and enjoyed your message on partnership and collaboration!

It that spirit of partnership and collaboration it is my honor to invite you, on behalf of our meeting Co-Chairs; (b) (6)

(b) (6) to give the Keynote Address at the PRIMO meeting (February 9-12, 2017 in Maui). The meeting will have some of the world's top Cancer experts present recent data on immuno and molecular oncology across a variety of tumor types. I will be happy to send you or your team any information you need. You can also find some of the details at www.primomeeting.org.

We hope you are both interested and available to attend and look forward to hearing back.

Best,

(b)

(b) (6)

(m) (b) (6)

www.cancerexpertnow.com

<image001.png> (b) (6)

<image002.png><image003.png>

Message

From: Poonam Alaigh [(b) (6)]@hotmail.com]
Sent: 12/5/2016 12:35:52 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] PRIMO Keynote Address

Sounds great- you should go most definitely, but don't know the hurdles that come my way though

Sent from my iPhone

On Dec 5, 2016, at 7:32 AM, David shulkin <Drshulkin@aol.com> wrote:

Maui in february?

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: December 5, 2016 at 7:04:22 AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
Subject: FW: [EXTERNAL] PRIMO Keynote Address

-----Original Message-----

From: [(b) (6)] [(b) (6)]@cancerexpertnow.com]
Sent: Sunday, December 04, 2016 08:13 PM Eastern Standard Time
To: Shulkin, David J., MD
Cc: [(b) (6)]
Subject: [EXTERNAL] PRIMO Keynote Address

Hi Dr. Shulkin,

It was a sincere pleasure to meet you on Friday in Dallas. I admired and enjoyed your message on partnership and collaboration!

It that spirit of partnership and collaboration it is my honor to invite you, on behalf of our meeting Co-Chairs; [(b) (6)] to give the Keynote Address at the PRIMO meeting (February 9-12, 2017 in Maui). The meeting will have some of the world's top Cancer experts present recent data on immuno and molecular oncology across a variety of tumor types. I will be happy to send you or your team any information you need. You can also find some of the details at www.primomeeting.org.

We hope you are both interested and available to attend and look forward to hearing back.

Best,

(b)
(6)

[REDACTED]

[REDACTED]

(m) (b) (6)

www.cancerexpertnow.com

<image001.(b) (6)>

<image002.png><image003.png>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 12:32:04 PM
To: Poonam Alaiht (b) (6) @hotmail.com]
Subject: Fwd: [EXTERNAL] PRIMO Keynote Address

Maui in february?

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: December 5, 2016 at 7:04:22 AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
Subject: FW: [EXTERNAL] PRIMO Keynote Address

-----Original Message-----

From: (b) (6) (b) (6) @cancerexpertnow.com]
Sent: Sunday, December 04, 2016 08:13 PM Eastern Standard Time
To: Shulkin, David J., MD
Cc: (b) (6)
Subject: [EXTERNAL] PRIMO Keynote Address

Hi Dr. Shulkin,

It was a sincere pleasure to meet you on Friday in Dallas. I admired and enjoyed your message on partnership and collaboration!

It that spirit of partnership and collaboration it is my honor to invite you, on behalf of our meeting Co-Chairs: (b) (6) to give the Keynote Address at the PRIMO meeting (February 9-12, 2017 in Maui). The meeting will have some of the world's top Cancer experts present recent data on immuno and molecular oncology across a variety of tumor types. I will be happy to send you or your team any information you need. You can also find some of the details at www.primomeeting.org.

We hope you are both interested and available to attend and look forward to hearing back.

Best,

(b) [REDACTED]
(6)

[REDACTED]

[REDACTED]

(m) (b) (6) [REDACTED]

www.cancerexpertnow.com

in (b) (6) [REDACTED]

CANCER
EXPERT NOW 



Message

From: (b) (6) (b) (6)@gmail.com]
Sent: 11/30/2016 6:39:07 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Mettle of honor - TulsaPeople - December 2016 - Tulsa, OK

<http://www.tulsapeople.com/Tulsa-People/December-2016/Mettle-of-honor/>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/15/2017 12:08:59 PM
To: (b) (6) (b) (6) @gmail.com]
Subject: Re: Website

Ok can yiu print this to remind me when i get to it this weekend

Sent from my iPhone

On Feb 15, 2017, at 7:05 AM, (b) (6) (b) (6) @gmail.com> wrote:

If you would like to keep it, you can change the phone number. It also says under secretary.

On Feb 15, 2017 7:03 AM, "David shulkin" <Drshulkin@aol.com> wrote:

I manage this

What do we need to do

Sent from my iPhone

On Feb 15, 2017, at 4:38 AM, (b) (6) (b) (6) @gmail.com> wrote:

Sir, who would like for me to connect with regarding your personal website.

<http://www.drshulkin.com/contact.html>

Message

From: (b) (6) (b) (6) gmail.com]
Sent: 2/15/2017 12:05:49 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Website

If you would like to keep it, you can change the phone number. It also says under secretary.

On Feb 15, 2017 7:03 AM, "David shulkin" <Drshulkin@aol.com> wrote:

I manage this

What do we need to do

Sent from my iPhone

On Feb 15, 2017, at 4:38 AM, (b) (6) (b) (6) @gmail.com> wrote:

Sir, who would like for me to connect with regarding your personal website.

<http://www.drshulkin.com/contact.html>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/15/2017 12:03:14 PM
To: (b) (6) (b) (6)@gmail.com]
Subject: Re: Website

I manage this

What do we need to do

Sent from my iPhone

On Feb 15, 2017, at 4:38 AM, (b) (6) (b) (6)@gmail.com> wrote:

Sir, who would like for me to connect with regarding your personal website.

<http://www.drshulkin.com/contact.html>

Message

From: (b) (6) (b) (6)@gmail.com]
Sent: 2/15/2017 9:38:37 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Website

Sir, who would like for me to connect with regarding your personal website.

<http://www.drshulkin.com/contact.html>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/11/2016 6:11:03 PM
To: Poonam Alaigh [REDACTED]@hotmail.com]
Subject: Re: Stay resolute

Ok ive got enough optimism for both of us- stay "poonam" positive

Sent from my iPhone

> On Nov 11, 2016, at 8:24 AM, Poonam Alaigh [REDACTED]@hotmail.com> wrote:

>

> I woke up with such a sense of despair and a feeling of hollowness- have heard from friends and some of the 1st, 2nd and 3rd hand stories of what our children are going through. I am fearful that we are going back in time 50 years and weakening the very foundation of our country that has made us the greatest place on earth. Not in a good state of mind and then I have a meeting with Brian - where I know I will be so disengaged and unperturbed - in the big scheme of things, this is so petty today

>

> Sent from my iPhone

Message

From: Poonam Alaigh [REDACTED]@hotmail.com]
Sent: 11/11/2016 1:24:36 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Stay resolute

I woke up with such a sense of despair and a feeling of hollowness- have heard from friends and some of the 1st, 2nd and 3rd hand stories of what our children are going through. I am fearful that we are going back in time 50 years and weakening the very foundation of our country that has made us the greatest place on earth. Not in a good state of mind and then I have a meeting with Brian - where I know I will be so disengaged and unperturbed - in the big scheme of things, this is so petty today

Sent from my iPhone

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/30/2016 3:14:21 PM
To: [REDACTED]@gmail.com
Subject: slides for the surgeon general conference
Attachments: wholehealthshort.pptx



VA

U.S. Department
of Veterans Affairs

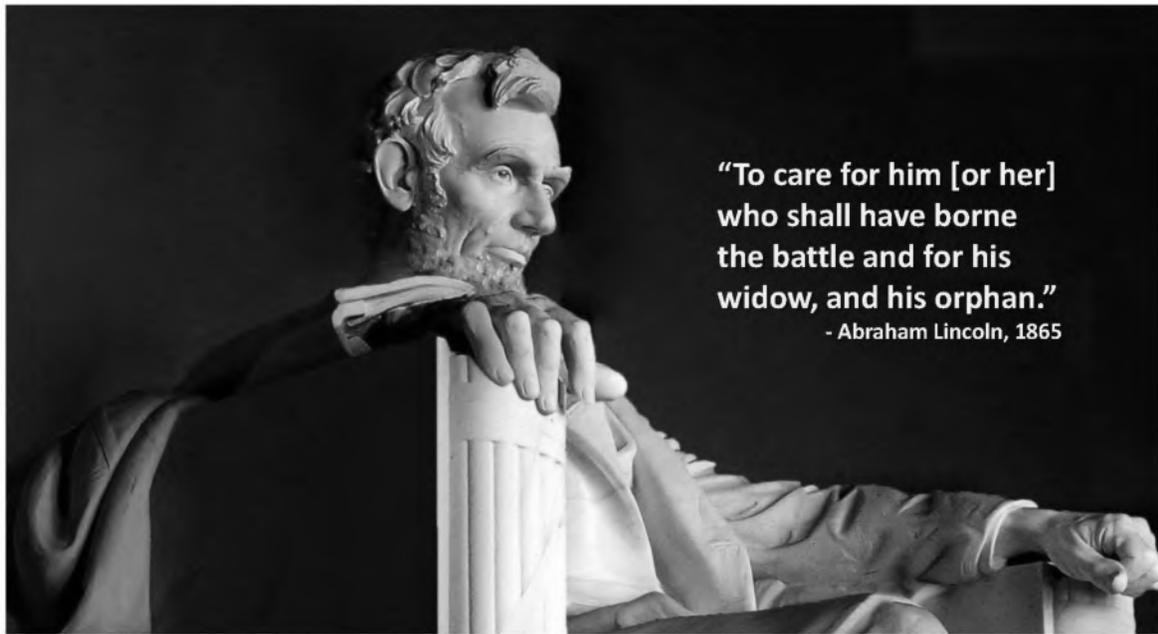
Redesigning Health Care to Promote One's Whole Health?

Veterans Health Administration

David J. Shulkin, M.D.
Under Secretary for Health

January 9, 2017

Fulfilling Our Mission



**“To care for him [or her]
who shall have borne
the battle and for his
widow, and his orphan.”**

- Abraham Lincoln, 1865

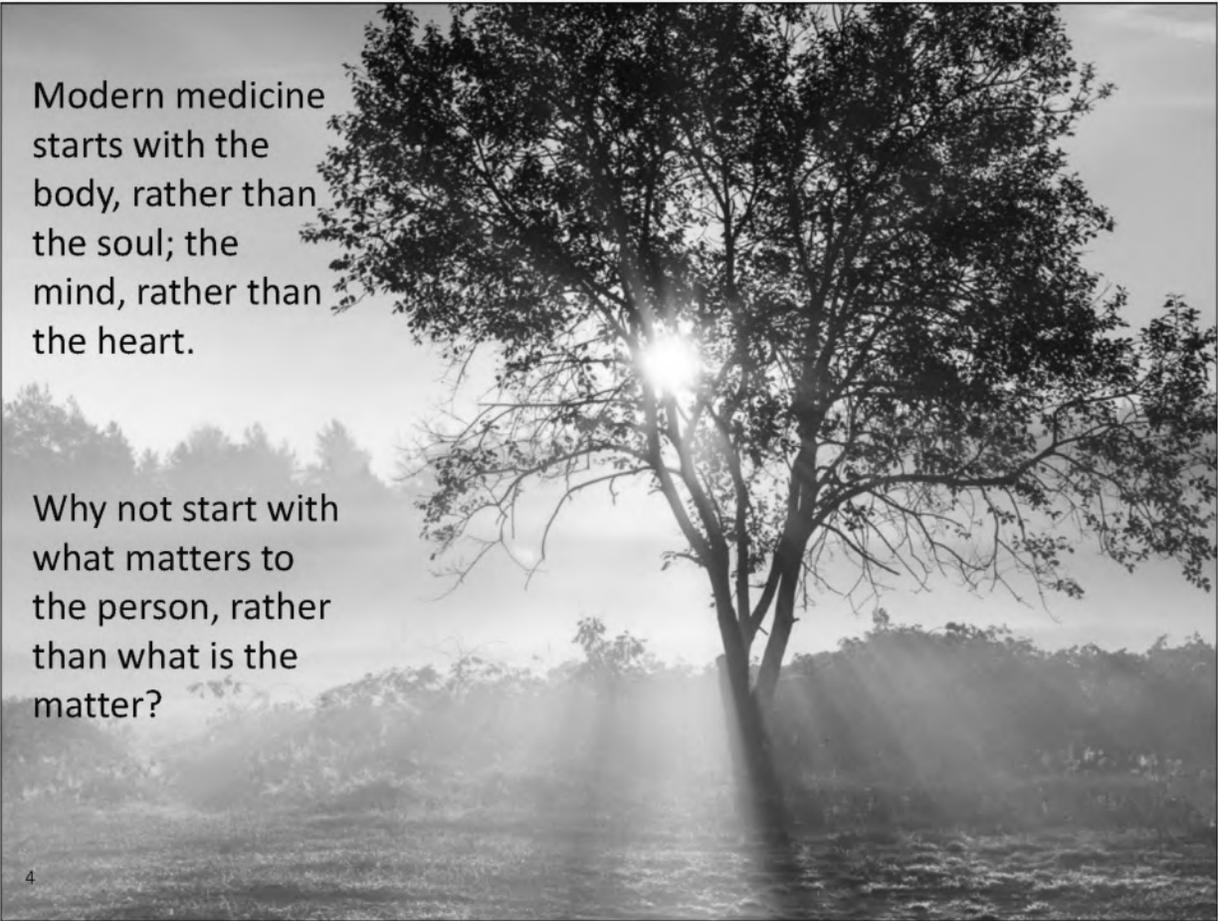
In Their Own Words



Modern medicine
starts with the
body, rather than
the soul; the
mind, rather than
the heart.

Why not start with
what matters to
the person, rather
than what is the
matter?

4



Learning Medicine on the Ski Slopes



VA



U.S. Department
of Veterans Affairs

Whole Health Partnership

Whole Health is an approach to health care that empowers AND equips people to take charge of their health and well-being, and live life to the fullest

The Whole Health Partnership was developed by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in collaboration with the Veteran Experience Committee (VEC) and endorsed by the National Leadership Council (NLC). In sum, the Whole Health Partnership is a systematic approach to provide whole health care early in the relationship between VA and the Veteran, emphasizing self-care in the larger context of well-being, and incorporating a full range of conventional and complementary and integrative health approaches. The Whole Health Partnership would move VA from focusing on episodic care to a more continuous engagement with the Veteran throughout his/her life. Additionally, the Whole Health Partnership model is the current vision for complementary and integrative health (CIH) integration in VA. The health care crisis in the United States has led to a call for transformation to a proactive model of care; VA has the opportunity to become the national leader in Whole Health care delivery and the Whole Health Partnership model is a roadmap to this paradigm shift.

Whole Health Model of Care



The NEW ENGLAND
JOURNAL of MEDICINE

HOME ARTICLES & MULTIMEDIA ▾ ISSUES ▾ SPECIALTIES & TOPICS ▾ FOR AUTHORS ▾ CME ▾



Perspective

Beyond the VA Crisis — Becoming a High-Performance Network

David J. Shulkin, M.D.

N Engl J Med 2016; 374:1003-1005 | March 17, 2016 | DOI: 10.1056/NEJMp1600307

“Our ‘whole health’ model of care is a key component of VA’s proposed future delivery system. This model incorporates physical care with psychosocial care focused on the Veteran’s personal health and life goals, aiming to provide personalized, proactive, patient-driven care through multidisciplinary teams of health professionals.”

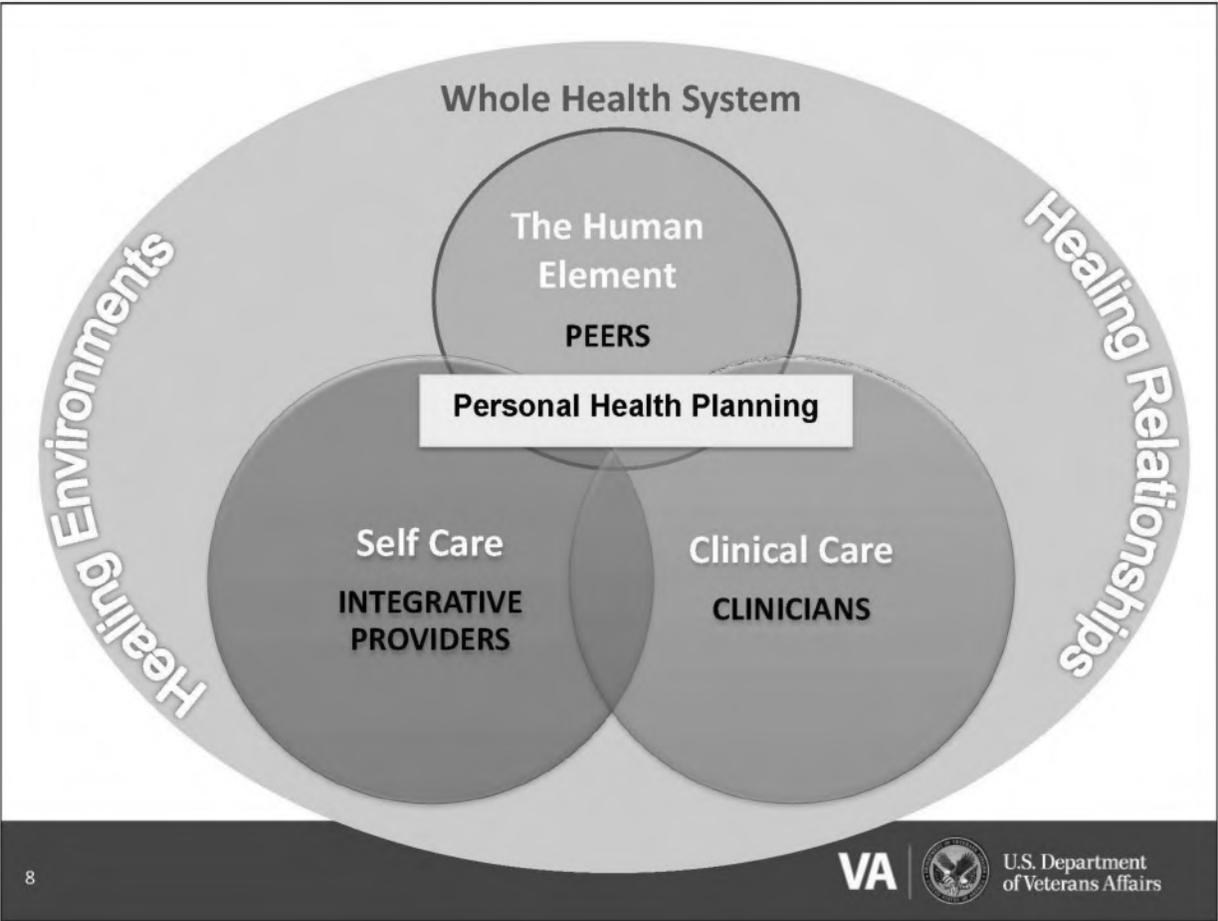
7

VA



U.S. Department
of Veterans Affairs

Starting with the VHA Strategic Plan, and including the Blueprint for Excellence and this recent article in the NEJM, VHA is talking about WH as the future model of VA care.



Whole Health System: FY 2016 and FY 2017



● = FY 2016 Whole Health Facilities

★ = FY 2017 Whole Health Facilities

Why it Matters to Start With What Really Matters

People with a sense of purpose had a **15%** lower risk of death compared to those who said they were aimless

*And what happens if we intentionally
link health care to this purpose?*

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/15/2016 2:54:27 AM
To: Poonam Alaigh [(b) (6)]@hotmail.com
Subject: Re: [(b) (6)] health insurance

Good PR but nothing really that special- am i missing something?

Sent from my iPhone

On Dec 14, 2016, at 5:37 PM, Poonam Alaigh [(b) (6)]@hotmail.com> wrote:

<http://www.businessinsider.com/oscar-center-a-tour-inside-the-doctors-office-of-the-future-photos-2016-12/#the-oscar-center-has-been-open-for-about-three-weeks-and-is-located-in-brooklyn-heights-right-next-door-to-the-jay-street-metrotech-subway-stop-1>

Message

From: Poonam Alaiht [b] (6) [redacted]@hotmail.com]
Sent: 12/14/2016 10:37:54 PM
To: David Shulkin [drshulkin@aol.com]
Subject: [b] [redacted] health insurance

<http://www.businessinsider.com/oscar-center-a-tour-inside-the-doctors-office-of-the-future-photos-2016-12/#the-oscar-center-has-been-open-for-about-three-weeks-and-is-located-in-brooklyn-heights-right-next-door-to-the-jay-street-metrotech-subway-stop-1>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/17/2016 4:27:12 PM
To: Jennifer Lee (b) (6) @gmail.com]
Subject: Fwd: Checking In

Sent from my iPhone

Begin forwarded message:

From: David shulkin <Drshulkin@aol.com>
Date: November 17, 2016 at 9:29:23 AM CST
To: William S Gould (b) (6) @verizon.net>
Cc: David Shulkin <drshulkin@aol.com>
Subject: Re: Checking In

7 th works- ill invite Jen

Sent from my iPhone

On Nov 17, 2016, at 9:21 AM, William S Gould <(b) (6) @verizon.net> wrote:

David:

Thanks. Good dates for lunch as follows: Nov 28, 29, 30 and Dec 2, 5, 7 and 8th

Breakfast on any day the week of Nov 29 to Dec 2 or Dec 5 - 9.

Would you like to do this with Jen?

BR,

Scott

W. Scott Gould

(b) (6)

cell: (b) (6)

tel: [REDACTED]

Prior email below for quick reference.

David:

I can do any day for lunch in November except the Thanksgiving break (23rd - 25th) Idea: head to lunch separately after the Arlington ceremony tomorrow near VACO?

Also, wanted to offer to do a three way ³murder board² with you and Jen. (Raul Henze has some great perspective on this process as well.) We could try out the talking points and approach that would be needed to prepare for a meeting with Baligh, anticipate likely objections and discuss concerns.

Then I'd recommend convening a three way session with you, Jen and Baligh in which you state your objective and ask him for his proposal to make it happen. This should be a chance for Baligh to approach the proposal afresh. (For example, I understand that there may be lingering concerns about using bundled payments under Choice. Since the proposal to use a bundled payment approach was withdrawn over 5 months ago, it should not be a factor.) And its a chance for Jen to lay our her clinical/policy level direction. Finally, you can state your preferences and provide direction. Having all three of you in the room will help avoid communications breakdowns and enhance clarity.

Finally, once you have provided Baligh with your guidance and intent to conduct a demonstration prohect under your authority as USVHA and received his proposal, put the entire documentation in front of your GC and ask for their review on all aspects of the proposal.

Your intent to address an underserved SUD population at a time of national crisis is admirable. That you are using a method developed at VHA that is roughly 3x more effective and 2/3 the cost of current VHA treatment is good care and good business. That there are five pilot sites in the VHA system today where SUD patients can't get access to care is an access problem that calls for care in the community. VHA is learning to scale an

internal success which reflects well on the career team's ability to innovate. In my view, this is the kind of innovation for which demonstration authorities were designed and you are well within your rights to ask your team to respond positively and timely.

Looking forward to catching up and appreciate all your efforts here.

BR,

Scott

On 11/17/16, 12:04 AM, "David shulkin" <Drshulkin@aol.com> wrote:

Scott- i hope i didnt miss an email.

Im in new orleans now for two days to open the new medical center and then traveling early next week then the holiday and with the new transition team early the following but lets grt together after that for sure

David

Sent from my iPhone

On Nov 16, 2016, at 7:42 PM, William S Gould
(b) (6) <[\[REDACTED\]@verizon.net](mailto:[REDACTED]@verizon.net)>

wrote:

David:

Working through the consequences of last Tuesday;
a lot to absorb.

Any reaction to my last email? Ready to assist.

BR,

Scott

W. Scott Gould

[REDACTED]

[REDACTED]

cell: [REDACTED]

tel: [REDACTED]

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/4/2016 8:29:41 PM
To: (b) (6) (b) (6) [va.gov]
Subject: Fwd: RWJ Clinical Scholar

Can we set up a call time- 20 min in january

Sent from my iPhone

Begin forwarded message:

From: SreyRam Kuy (b) (6) @gmail.com>
Date: December 4, 2016 at 3:03:47 PM EST
To: David shulkin <Drshulkin@aol.com>
Subject: Re: RWJ Clinical Scholar

Dr. Shulkin,

Yes, January would be great! I absolutely understand, it must be extraordinarily busy with transition going on. Please know that if there's any way I can help or contribute at all during this very busy time, I'd be more than delighted to do so!

Warmly,
SreyRam

SreyRam Kuy, MD, MHS, FACS

On Sat, Dec 3, 2016 at 10:23 PM, David shulkin <Drshulkin@aol.com> wrote:

Id be glad to- though very busy now with the transition of administration
Can we talk in january?

Sent from my iPhone

On Dec 3, 2016, at 7:30 PM, SreyRam Kuy
(b) (6) @gmail.com> wrote:

Hi Dr. Shulkin,

I hope you and your family had a good Thanksgiving. Thanks so much

for answering my email a few weeks ago. I really appreciate it! As a former RWJ Clinical Scholar, I'm so inspired by your leadership in healthcare policy and the work you've done to improve health for our veterans. Thank you for all you do!

I'm interested in exploring opportunities to be a part of the healthcare policy process in Washington DC. If you have time, I would love to have the chance to chat with you about any possibilities in DC. I've attached my CV, a bio, as well as a few articles discussing my work at the VA and at Medicaid.

In advance, thank you so much for your kind consideration. -
SreyRam

SreyRam Kuy, MD, MHS, FACS

Phone: (b) (6)

Email: (b) (6)@gmail.com; SreyRam.Kuy@la.gov

Bio:

SreyRam Kuy, MD, MHS, is Chief Medical Officer for Medicaid in the

Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr.

Kuy leads the drive for improving healthcare quality, promoting cost

effectiveness and increasing health information technology adoption in

a \$7.5 billion health system serving 1.6 million patients. Under her leadership, Louisiana Medicaid was the first state to develop a Zika

prevention strategy for pregnant Medicaid patients; enabled women with

breast cancer to have access to needed reconstructive surgery and BRCA

testing, led efforts to coordinate medical disaster relief efforts during Louisiana's Great Flood, and is leading Louisiana Medicaid's

initiative to tackle the opioid epidemic. She has developed state

wide health performance metrics, pay for performance incentives, and established novel “Medicaid Expansion Early Wins measures” which enable the state of Louisiana to assess how Medicaid expansion directly impacts lives.

Prior to serving as Chief Medical Officer for Louisiana Medicaid, Dr.

Kuy has served in numerous leadership roles, including Director of the

Center for Innovations in Quality, Outcomes and Patient Safety, Assistant Chief of General Surgery, Chair of the Systems Redesign Committee, and on the Quality, Safety & Value Board at Overton Brooks

VA Medical Center. Dr. Kuy’s work successfully reducing patient mortality & morbidity and decreasing adverse safety events was profiled by the VA National Center for Patient Safety. Her work increasing veterans’ access to care through clinic efficiency was profiled by the Association for VA Surgeons, and templates she developed were disseminated for implementation at VA medical centers

across the country. Dr. Kuy is deeply committed to caring for our veterans, and has more than a decade of experience serving in VA systems across the country in Oregon, Texas, Connecticut, Wisconsin and Louisiana.

Dr. Kuy grew up in Oregon, graduated as Valedictorian from Crescent

Valley High School, and attended Oregon State University where she

earned dual degrees in Philosophy and Microbiology. She attended medical school at Oregon Health & Sciences University, then finished

general surgery residency. Dr. Kuy earned her master’s degree in health policy, public health and outcomes research at Yale University

School of Medicine as a Robert Wood Johnson Clinical Scholar. She

worked as a Kaiser Family Foundation Health Policy Scholar in the US

Senate in Washington DC.

Dr. Kuy has served in state and national leadership roles in healthcare and health policy. She served as a Board Member on the National Board of Medical Examiners and the Federation of State Medical Boards' representative on the Accreditation Council for Continuing Medical Education. Dr. Kuy has served on several national committees on healthcare policy, quality and safety, including the AcademyHealth State Health Research and Policy Interest Group Advisory Committee, National Quality Forum Medicaid Innovation Accelerator Committee, Alliance for a Healthier Generation's Obesity Prevention Task Force, Commission on HIV, AIDS and Hep C, Taskforce on Telehealth, Commission on Opioids, and the American College of Surgeons' Diversity Committee. Dr. Kuy has published more than 40 articles in JAMA Surgery, Surgery, American Journal of Surgery and other medical journals on healthcare quality and patient safety. Her textbook, "Fifty Studies Every Surgeon Should Know", will be released by Oxford University Press. She has also written for the Los Angeles Times, USA Today, Washington Post, The Independent, Salon and the Huffington Post. Dr. Kuy received Business Report's 40 Under 40 Award in 2016 for her work to improve healthcare quality in the Louisiana Medicaid population and the Ford Foundation's Gerald E. Bruce Community Service Award for her work serving veterans.

Read about Dr. Kuy's work reducing mortality and patient safety adverse events profiled in the VA National Center for Patient Safety

here:

http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp

Read about Dr. Kuy's work improving veterans' access to care through clinic efficiency profiled by the Association of VA Surgeons here: <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>

Read about Dr. Kuy's work at Louisiana Medicaid improving healthcare quality profiled by Mostly Medicaid here: <http://www.mostlymedicaid.com/?p=1821>

Read about Dr. Kuy's work with Medicaid Expansion to improve patient health profiled by Business Reports 40 Under 40 here: <https://www.businessreport.com/article/forty-40-qa-sreyram-kuy>

On Tue, Nov 8, 2016 at 9:02 AM, David shulkin <Drshulkin@aol.com> wrote:

I would love too- but the next few weeks post election are the very toughest time for me- im fully engaged every minute- can we connect after thanksgiving?

Sent from my iPhone

On Nov 8, 2016, at 9:56 AM,
SreyRam Kuy
(b) (6) <[\(b\) \(6\)@gmail.com](mailto:(b) (6)@gmail.com)> wrote:

Dr. Shulkin,

I'm a former RWJ Clinical Scholar. I am so inspired by your work in

healthcare and serving our veterans. I wanted to respectfully ask if

you might have a few minutes to chat about advice and opportunities for a physician with a passion for healthcare quality and caring for our veterans? I would love the chance to hear your thoughts and suggestions.

Briefly, I'm a surgeon with a deep commitment to caring for our nation's veterans and promoting healthcare quality. Previously, as Assistant Chief of General Surgery and Director of the Center for Innovations in Quality, Outcomes and Patient Safety at Overton Brooks VA Medical Center, I worked to reduce patient mortality and decrease patient safety adverse events. Our team's work was profiled by the VA National Center for Patient Safety and the Association of VA Surgeons. I received the Ford Foundation Community Service Award, and was able to donate the \$5,000 award to our local veteran's group. Currently, as Chief Medical Officer for Louisiana's Medicaid, I work to promote quality, safety and accountable healthcare for the 1.6 million lives we care for in a \$7.5 billion health system. I'm deeply committed to helping improving healthcare quality, and to serving our veterans.

I would love the chance to talk with you about your work, your advice

and opportunities you could suggest. Thank you so much for your time

and hope to hear from you. I really appreciate it!

Thanks,
-SreyRam

SreyRam Kuy, MD, MHS, FACS

<http://www.mostlymedicaid.com/?p=1821>

http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp

<http://www.avasnews.com/single-post/2016/05/16/REDUCING-NOSHOWS>

Email [\(b\) \(6\)@gmail.com](mailto:(b) (6)@gmail.com) or sreyram.kuy@la.gov

Phone: (b) (6)

<Dr. SreyRam Kuy CV.pdf>

<Dr. SreyRam Kuy Bio.pdf>

<VA National Center for Patient Safety article - Dr. Kuy.pdf>

<Association of VA Surgeons - Dr. Kuy.pdf>

<Mostly Medicaid - Dr. Kuy.pdf>

<Business Report 40 Under 40 - Dr. Kuy.pdf>

Message

From: SreyRam Kuy [REDACTED]@gmail.com]
Sent: 12/4/2016 8:03:47 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: RWJ Clinical Scholar

Dr. Shulkin,

Yes, January would be great! I absolutely understand, it must be extraordinarily busy with transition going on. Please know that if there's any way I can help or contribute at all during this very busy time, I'd be more than delighted to do so!

Warmly,
SreyRam

SreyRam Kuy, MD, MHS, FACS

On Sat, Dec 3, 2016 at 10:23 PM, David shulkin <Drshulkin@aol.com> wrote:
> Id be glad to- though very busy now with the transition of administration
> Can we talk in january?

>
> Sent from my iPhone

>
>> On Dec 3, 2016, at 7:30 PM, SreyRam Kuy [REDACTED]@gmail.com> wrote:

>>
>> Hi Dr. Shulkin,

>>
>> I hope you and your family had a good Thanksgiving. Thanks so much
>> for answering my email a few weeks ago. I really appreciate it! As a
>> former RWJ Clinical Scholar, I'm so inspired by your leadership in
>> healthcare policy and the work you've done to improve health for our
>> veterans. Thank you for all you do!

>>
>> I'm interested in exploring opportunities to be a part of the
>> healthcare policy process in Washington DC. If you have time, I would
>> love to have the chance to chat with you about any possibilities in
>> DC. I've attached my CV, a bio, as well as a few articles discussing
>> my work at the VA and at Medicaid.

>>
>> In advance, thank you so much for your kind consideration. -SreyRam

>>
>> SreyRam Kuy, MD, MHS, FACS

>> Phone:

>> Email: [REDACTED]@gmail.com; SreyRam.Kuy@la.gov

>> Bio:

>> SreyRam Kuy, MD, MHS, is Chief Medical Officer for Medicaid in the
>> Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr.
>> Kuy leads the drive for improving healthcare quality, promoting cost
>> effectiveness and increasing health information technology adoption in
>> a \$7.5 billion health system serving 1.6 million patients. Under her
>> leadership, Louisiana Medicaid was the first state to develop a Zika
>> prevention strategy for pregnant Medicaid patients; enabled women with
>> breast cancer to have access to needed reconstructive surgery and BRCA
>> testing, led efforts to coordinate medical disaster relief efforts
>> during Louisiana's Great Flood, and is leading Louisiana Medicaid's
>> initiative to tackle the opioid epidemic. She has developed state
>> wide health performance metrics, pay for performance incentives, and
>> established novel "Medicaid Expansion Early Wins measures" which
>> enable the state of Louisiana to assess how Medicaid expansion
>> directly impacts lives.

>>
>> Prior to serving as Chief Medical Officer for Louisiana Medicaid, Dr.
>> Kuy has served in numerous leadership roles, including Director of the
>> Center for Innovations in Quality, Outcomes and Patient Safety,
>> Assistant Chief of General Surgery, Chair of the Systems Redesign
>> Committee, and on the Quality, Safety & Value Board at Overton Brooks
>> VA Medical Center. Dr. Kuy's work successfully reducing patient

>>>> suggestions.
>>>>
>>>> Briefly, I'm a surgeon with a deep commitment to caring for our
>>>> nation's veterans and promoting healthcare quality. Previously, as
>>>> Assistant Chief of General Surgery and Director of the Center for
>>>> Innovations in Quality, Outcomes and Patient Safety at Overton Brooks
>>>> VA Medical Center, I worked to reduce patient mortality and decrease
>>>> patient safety adverse events. Our team's work was profiled by the VA
>>>> National Center for Patient Safety and the Association of VA Surgeons.
>>>> I received the Ford Foundation Community Service Award, and was able
>>>> to donate the \$5,000 award to our local veteran's group. Currently,
>>>> as Chief Medical Officer for Louisiana's Medicaid, I work to promote
>>>> quality, safety and accountable healthcare for the 1.6 million lives
>>>> we care for in a \$7.5 billion health system. I'm deeply committed to
>>>> helping improving healthcare quality, and to serving our veterans.
>>>>
>>>> I would love the chance to talk with you about your work, your advice
>>>> and opportunities you could suggest. Thank you so much for your time
>>>> and hope to hear from you. I really appreciate it!
>>>>
>>>> Thanks,
>>>> -SreyRam
>>>>
>>>>
>>>> SreyRam Kuy, MD, MHS, FACS
>>>>
>>>> <http://www.mostlymedicaid.com/?p=1821>
>>>> http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp
>>>> <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>
>>>>
>>>>
>>>> Email: [REDACTED]@gmail.com or sreyram.kuy@la.gov
>>>> Phone: [REDACTED]
>>>>
>> <Dr. SreyRam Kuy CV.pdf>
>> <Dr. SreyRam Kuy Bio.pdf>
>> <VA National Center for Patient Safety article - Dr. Kuy.pdf>
>> <Association of VA Surgeons - Dr. Kuy.pdf>
>> <Mostly Medicaid - Dr. Kuy.pdf>
>> <Business Report 40 Under 40 - Dr. Kuy.pdf>
>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/4/2016 4:23:02 AM
To: SreyRam Kuy [REDACTED]@gmail.com]
Subject: Re: RWJ Clinical Scholar

Id be glad to- though very busy now with the transition of administration
Can we talk in january?

Sent from my iPhone

> On Dec 3, 2016, at 7:30 PM, SreyRam Kuy [REDACTED]@gmail.com> wrote:
>
> Hi Dr. Shulkin,
>
> I hope you and your family had a good Thanksgiving. Thanks so much
> for answering my email a few weeks ago. I really appreciate it! As a
> former RWJ Clinical Scholar, I'm so inspired by your leadership in
> healthcare policy and the work you've done to improve health for our
> veterans. Thank you for all you do!
>
> I'm interested in exploring opportunities to be a part of the
> healthcare policy process in Washington DC. If you have time, I would
> love to have the chance to chat with you about any possibilities in
> DC. I've attached my CV, a bio, as well as a few articles discussing
> my work at the VA and at Medicaid.
>
> In advance, thank you so much for your kind consideration. -SreyRam
>
> SreyRam Kuy, MD, MHS, FACS
> Phone: [REDACTED]
> Email: [REDACTED]@la.gov
>
> Bio:
> SreyRam Kuy, MD, MHS, is Chief Medical Officer for Medicaid in the
> Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr.
> Kuy leads the drive for improving healthcare quality, promoting cost
> effectiveness and increasing health information technology adoption in
> a \$7.5 billion health system serving 1.6 million patients. Under her
> leadership, Louisiana Medicaid was the first state to develop a Zika
> prevention strategy for pregnant Medicaid patients; enabled women with
> breast cancer to have access to needed reconstructive surgery and BRCA
> testing, led efforts to coordinate medical disaster relief efforts
> during Louisiana's Great Flood, and is leading Louisiana Medicaid's
> initiative to tackle the opioid epidemic. She has developed state
> wide health performance metrics, pay for performance incentives, and
> established novel "Medicaid Expansion Early Wins measures" which
> enable the state of Louisiana to assess how Medicaid expansion
> directly impacts lives.
>
> Prior to serving as Chief Medical Officer for Louisiana Medicaid, Dr.
> Kuy has served in numerous leadership roles, including Director of the
> Center for Innovations in Quality, Outcomes and Patient Safety,
> Assistant Chief of General Surgery, Chair of the Systems Redesign
> Committee, and on the Quality, Safety & Value Board at Overton Brooks
> VA Medical Center. Dr. Kuy's work successfully reducing patient
> mortality & morbidity and decreasing adverse safety events was
> profiled by the VA National Center for Patient Safety. Her work
> increasing veterans' access to care through clinic efficiency was
> profiled by the Association for VA Surgeons, and templates she
> developed were disseminated for implementation at VA medical centers
> across the country. Dr. Kuy is deeply committed to caring for our
> veterans, and has more than a decade of experience serving in VA
> systems across the country in Oregon, Texas, Connecticut, Wisconsin
> and Louisiana.
>
> Dr. Kuy grew up in Oregon, graduated as Valedictorian from Crescent
> Valley High School, and attended Oregon State University where she
> earned dual degrees in Philosophy and Microbiology. She attended
> medical school at Oregon Health & Sciences University, then finished
> general surgery residency. Dr. Kuy earned her master's degree in
> health policy, public health and outcomes research at Yale University

> School of Medicine as a Robert Wood Johnson Clinical Scholar. She
> worked as a Kaiser Family Foundation Health Policy Scholar in the US
> Senate in Washington DC.
>
> Dr. Kuy has served in state and national leadership roles in
> healthcare and health policy. She served as a Board Member on the
> National Board of Medical Examiners and the Federation of State
> Medical Boards' representative on the Accreditation Council for
> Continuing Medical Education. Dr. Kuy has served on several national
> committees on healthcare policy, quality and safety, including the
> AcademyHealth State Health Research and Policy Interest Group Advisory
> Committee, National Quality Forum Medicaid Innovation Accelerator
> Committee, Alliance for a Healthier Generation's Obesity Prevention
> Task Force, Commission on HIV, AIDS and Hep C, Taskforce on
> Telehealth, Commission on Opioids, and the American College of
> Surgeons' Diversity Committee. Dr. Kuy has published more than 40
> articles in JAMA Surgery, Surgery, American Journal of Surgery and
> other medical journals on healthcare quality and patient safety. Her
> textbook, "Fifty Studies Every Surgeon Should Know", will be released
> by Oxford University Press. She has also written for the Los Angeles
> Times, USA Today, Washington Post, The Independent, Salon and the
> Huffington Post. Dr. Kuy received Business Report's 40 Under 40 Award
> in 2016 for her work to improve healthcare quality in the Louisiana
> Medicaid population and the Ford Foundation's Gerald E. Bruce
> Community Service Award for her work serving veterans.
>
> Read about Dr. Kuy's work reducing mortality and patient safety
> adverse events profiled in the VA National Center for Patient Safety
> here: http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp
>
> Read about Dr. Kuy's work improving veterans' access to care through
> clinic efficiency profiled by the Association of VA Surgeons here:
> <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>
>
> Read about Dr. Kuy's work at Louisiana Medicaid improving healthcare
> quality profiled by Mostly Medicaid here:
> <http://www.mostlymedicaid.com/?p=1821>
>
> Read about Dr. Kuy's work with Medicaid Expansion to improve patient
> health profiled by Business Reports 40 Under 40 here:
> <https://www.businessreport.com/article/forty-40-qa-sreyram-kuy>
>
>
>
>
>
>
>

>> On Tue, Nov 8, 2016 at 9:02 AM, David shulkin <Drshulkin@aol.com> wrote:
>> I would love too- but the next few weeks post election are the very toughest time for me- im fully
>> engaged every minute- can we connect after thanksgiving?

>>> Sent from my iPhone

>>> On Nov 8, 2016, at 9:56 AM, SreyRam Kuy [REDACTED]@gmail.com> wrote:

>>> Dr. Shulkin,

>>> I'm a former RWJ Clinical Scholar. I am so inspired by your work in
>>> healthcare and serving our veterans. I wanted to respectfully ask if
>>> you might have a few minutes to chat about advice and opportunities
>>> for a physician with a passion for healthcare quality and caring for
>>> our veterans? I would love the chance to hear your thoughts and
>>> suggestions.

>>> Briefly, I'm a surgeon with a deep commitment to caring for our
>>> nation's veterans and promoting healthcare quality. Previously, as
>>> Assistant Chief of General Surgery and Director of the Center for
>>> Innovations in Quality, Outcomes and Patient Safety at Overton Brooks
>>> VA Medical Center, I worked to reduce patient mortality and decrease
>>> patient safety adverse events. Our team's work was profiled by the VA
>>> National Center for Patient Safety and the Association of VA Surgeons.
>>> I received the Ford Foundation Community Service Award, and was able
>>> to donate the \$5,000 award to our local veteran's group. Currently,
>>> as Chief Medical Officer for Louisiana's Medicaid, I work to promote
>>> quality, safety and accountable healthcare for the 1.6 million lives
>>> we care for in a \$7.5 billion health system. I'm deeply committed to
>>> helping improving healthcare quality, and to serving our veterans.

>>> I would love the chance to talk with you about your work, your advice
>>> and opportunities you could suggest. Thank you so much for your time
>>> and hope to hear from you. I really appreciate it!
>>>
>>> Thanks,
>>> -SreyRam
>>>
>>>
>>> SreyRam Kuy, MD, MHS, FACS
>>>
>>> <http://www.mostlymedicaid.com/?p=1821>
>>> http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp
>>> <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>
>>>
>>>
>>> Email: [REDACTED]@gmail.com or sreyram.kuy@va.gov
>>> Phone: [REDACTED]
>>
> <Dr. SreyRam Kuy CV.pdf>
> <Dr. SreyRam Kuy Bio.pdf>
> <VA National Center for Patient Safety article - Dr. Kuy.pdf>
> <Association of VA Surgeons - Dr. Kuy.pdf>
> <Mostly Medicaid - Dr. Kuy.pdf>
> <Business Report 40 Under 40 - Dr. Kuy.pdf>

Message

From: SreyRam Kuy [REDACTED]@gmail.com]
Sent: 12/4/2016 12:30:37 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: RWJ Clinical Scholar
Attachments: Dr. SreyRam Kuy CV.pdf; Dr. SreyRam Kuy Bio.pdf; VA National Center for Patient Safety article - Dr. Kuy.pdf; Association of VA Surgeons - Dr. Kuy.pdf; Mostly Medicaid - Dr. Kuy.pdf; Business Report 40 Under 40 - Dr. Kuy.pdf

Hi Dr. Shulkin,

I hope you and your family had a good Thanksgiving. Thanks so much for answering my email a few weeks ago. I really appreciate it! As a former RWJ Clinical Scholar, I'm so inspired by your leadership in healthcare policy and the work you've done to improve health for our veterans. Thank you for all you do!

I'm interested in exploring opportunities to be a part of the healthcare policy process in Washington DC. If you have time, I would love to have the chance to chat with you about any possibilities in DC. I've attached my CV, a bio, as well as a few articles discussing my work at the VA and at Medicaid.

In advance, thank you so much for your kind consideration. -SreyRam

SreyRam Kuy, MD, MHS, FACS
Phone: [REDACTED]
Email: [REDACTED]@gmail.com; SreyRam.Kuy@va.gov

Bio:
SreyRam Kuy, MD, MHS, is Chief Medical Officer for Medicaid in the Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr. Kuy leads the drive for improving healthcare quality, promoting cost effectiveness and increasing health information technology adoption in a \$7.5 billion health system serving 1.6 million patients. Under her leadership, Louisiana Medicaid was the first state to develop a Zika prevention strategy for pregnant Medicaid patients; enabled women with breast cancer to have access to needed reconstructive surgery and BRCA testing, led efforts to coordinate medical disaster relief efforts during Louisiana's Great Flood, and is leading Louisiana Medicaid's initiative to tackle the opioid epidemic. She has developed state wide health performance metrics, pay for performance incentives, and established novel "Medicaid Expansion Early Wins measures" which enable the state of Louisiana to assess how Medicaid expansion directly impacts lives.

Prior to serving as Chief Medical Officer for Louisiana Medicaid, Dr. Kuy has served in numerous leadership roles, including Director of the Center for Innovations in Quality, Outcomes and Patient Safety, Assistant Chief of General Surgery, Chair of the Systems Redesign Committee, and on the Quality, Safety & Value Board at Overton Brooks VA Medical Center. Dr. Kuy's work successfully reducing patient mortality & morbidity and decreasing adverse safety events was profiled by the VA National Center for Patient Safety. Her work increasing veterans' access to care through clinic efficiency was profiled by the Association for VA Surgeons, and templates she developed were disseminated for implementation at VA medical centers across the country. Dr. Kuy is deeply committed to caring for our veterans, and has more than a decade of experience serving in VA systems across the country in Oregon, Texas, Connecticut, Wisconsin and Louisiana.

Dr. Kuy grew up in Oregon, graduated as Valedictorian from Crescent Valley High School, and attended Oregon State University where she earned dual degrees in Philosophy and Microbiology. She attended medical school at Oregon Health & Sciences University, then finished general surgery residency. Dr. Kuy earned her master's degree in health policy, public health and outcomes research at Yale University School of Medicine as a Robert Wood Johnson Clinical Scholar. She worked as a Kaiser Family Foundation Health Policy Scholar in the US Senate in Washington DC.

Dr. Kuy has served in state and national leadership roles in healthcare and health policy. She served as a Board Member on the National Board of Medical Examiners and the Federation of State Medical Boards' representative on the Accreditation Council for Continuing Medical Education. Dr. Kuy has served on several national committees on healthcare policy, quality and safety, including the AcademyHealth State Health Research and Policy Interest Group Advisory Committee, National Quality Forum Medicaid Innovation Accelerator Committee, Alliance for a Healthier Generation's Obesity Prevention Task Force, Commission on HIV, AIDS and Hep C, Taskforce on Telehealth, Commission on Opioids, and the American College of Surgeons' Diversity Committee. Dr. Kuy has published more than 40 articles in JAMA Surgery, Surgery, American Journal of Surgery and other medical journals on healthcare quality and patient safety. Her textbook, "Fifty Studies Every Surgeon Should Know", will be released by Oxford University Press. She has also written for the Los Angeles Times, USA Today, Washington Post, The Independent, Salon and the Huffington Post. Dr. Kuy received Business Report's 40 Under 40 Award in 2016 for her work to improve healthcare quality in the Louisiana Medicaid population and the Ford Foundation's Gerald E. Bruce Community Service Award for her work serving veterans.

Read about Dr. Kuy's work reducing mortality and patient safety adverse events profiled in the VA National Center for Patient Safety here: http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp

Read about Dr. Kuy's work improving veterans' access to care through clinic efficiency profiled by the Association of VA Surgeons here: <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>

Read about Dr. Kuy's work at Louisiana Medicaid improving healthcare quality profiled by Mostly Medicaid here: <http://www.mostlymedicaid.com/?p=1821>

Read about Dr. Kuy's work with Medicaid Expansion to improve patient health profiled by Business Reports 40 Under 40 here: <https://www.businessreport.com/article/forty-40-qa-sreyram-kuy>

On Tue, Nov 8, 2016 at 9:02 AM, David shulkin <Drshulkin@aol.com> wrote:
> I would love too- but the next few weeks post election are the very toughest time for me- im fully engaged every minute- can we connect after thanksgiving?

>
> Sent from my iPhone

>
>> On Nov 8, 2016, at 9:56 AM, SreyRam Kuy [REDACTED]@gmail.com> wrote:

>>
>> Dr. Shulkin,
>>
>> I'm a former RWJ Clinical Scholar. I am so inspired by your work in
>> healthcare and serving our veterans. I wanted to respectfully ask if
>> you might have a few minutes to chat about advice and opportunities
>> for a physician with a passion for healthcare quality and caring for
>> our veterans? I would love the chance to hear your thoughts and
>> suggestions.

>>
>> Briefly, I'm a surgeon with a deep commitment to caring for our
>> nation's veterans and promoting healthcare quality. Previously, as
>> Assistant Chief of General Surgery and Director of the Center for
>> Innovations in Quality, Outcomes and Patient Safety at Overton Brooks
>> VA Medical Center, I worked to reduce patient mortality and decrease
>> patient safety adverse events. Our team's work was profiled by the VA
>> National Center for Patient Safety and the Association of VA Surgeons.
>> I received the Ford Foundation Community Service Award, and was able
>> to donate the \$5,000 award to our local veteran's group. Currently,
>> as Chief Medical Officer for Louisiana's Medicaid, I work to promote
>> quality, safety and accountable healthcare for the 1.6 million lives
>> we care for in a \$7.5 billion health system. I'm deeply committed to
>> helping improving healthcare quality, and to serving our veterans.
>>
>> I would love the chance to talk with you about your work, your advice
>> and opportunities you could suggest. Thank you so much for your time

>> and hope to hear from you. I really appreciate it!
>>
>> Thanks,
>> -SreyRam
>>
>>
>> SreyRam Kuy, MD, MHS, FACS
>>
>> <http://www.mostlymedicaid.com/?p=1821>
>> http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp
>> <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>
>>
>>
>> Email: [REDACTED]@gmail.com or sreeram.kuy@1a.gov
>> Phone: [REDACTED]
>

SreyRam Kuy, MD, MHS, FACS

**Chief Medical Officer, Medicaid
Louisiana Department of Health**

PERSONAL:

Office Address: Louisiana Medicaid, Department of Health

Mobile Telephone:

Office Telephone:

Email Address:

(b) [REDACTED]

(b) (6) [REDACTED]

(b) (6) [REDACTED]

(b) (6) [REDACTED]@gmail.com

SreyRam.Kuy@LA.Gov

EDUCATION:

- 2016 Executive Leadership Program for Health Policy and Management
Heller School of Policy and Management, Brandeis University
- 2009 M.H.S. (Master of Health Science)
Yale University School of Medicine, Robert Wood Johnson Clinical Scholar
- 2005 M.D. (Medical Degree)
Oregon Health & Sciences University School of Medicine
- 2000 B.S. (Bachelor of Science, Philosophy), magna cum laude
Oregon State University
- 2000 B.S. (Bachelor of Science, Microbiology), magna cum laude
Oregon State University

POSTGRADUATE TRAINING:

- 2009-2012 Residency, General Surgery (PGY 3-5)
Medical College of Wisconsin
- 2007-2009 Robert Wood Johnson Clinical Scholar Fellowship
Yale University School of Medicine
- 2005-2007 Residency, General Surgery (PGY 1-2)
University of Texas Health Sciences Center at San Antonio

APPOINTMENTS:

2016- Chief Medical Officer, Medicaid, Louisiana Department of Health and Hospitals
Louisiana Medicaid serves 1.6 million lives in a \$7.5 billion health system. My work includes managing the Quality Team, Pharmacy Team, Clinical Policy Team, Health Information Technology Team and a Benefits & Covered Services Team. In addition, I lead initiatives for emerging public health threats such as coordinating medical efforts at Flood Shelters, developing a Zika transmission prevention policy, and working with the Governor's office and legislatures to implement strategies tackling the opioid crisis.

- Health Information Technology Team: lead the state's electronic health record adoption initiative and health information technology strategy, oversee \$26 million CMS grant for Health Information Technology and a National Governors' Association HIT grant
- Quality Team: Develop and evaluate incentivized quality performance measures for providers & health plans to improve outcomes, safety, and quality of care for the state of Louisiana. Manage a Quality Team comprised of physicians, nurses & policy analysts addressing health care quality. Creation of a "Search by Score" site that promotes quality, transparency and adoption in Louisiana healthcare.
- Clinical Policy Team overseeing the evidence based approach for coverage of new benefits and services for Medicaid beneficiaries
- Benefits and Covered Services Team: manage all covered services and benefits in the Louisiana Medicaid system
- Pharmacy Team: overseeing Medicaid prescription coverage
- Rapidly respond to emergent public health issues (such as Zika virus, Opioid epidemic, drug shortages, flooding and emergency natural disasters) and develop guidance for providers and health plans
- Work with Louisiana healthcare stake holders, including Managed Care Organizations, hospital associations, healthcare providers, health facilities and institutions, patient advocacy groups to ensure high quality care for Louisiana's Medicaid population, and efficient use of resources

2014-2016 Director, Center for Innovations in Quality, Outcomes and Patient Safety, OBVAMC

- Develop and lead initiatives to meet Joint Commission ORYX core measures, SAIL performance measures, and monitor PSI occurrences.
- Develop programs that lead to sustained improvement in quality, outcomes and safety in the Surgical Services at the OBVAMC.
- Work on reducing mortality and adverse events profiled in the VA National Center for Patient Safety newsletter and website. Work on decreasing clinic no-shows featured in the Association of VA Surgeons newsletter and website.
- Collaborate with section chiefs to assess needs for quality improvement; develop, monitor and assess quality measures and initiatives; monitor analyze and assess surgical outcomes; integrate quality improvement tools

and surgical outcome measures to create a cohesive program for the OBVAMC Surgical Services.

- Partner with VA clinical, policy and operational leaders to implement and evaluate different ways to make surgical healthcare safer, more effective and more affordable.

- 2015-2016 Assistant Chief, General Surgery Section
Overton Brooks VA Medical Center (OBVAMC)
- Integrate quality improvement tools and surgical outcome measures to create a cohesive program for General Surgery Section, leading to improved patient safety with a decrease in patient mortality and reduction in Critical Incident Network Tracking adverse events
 - Work on SAIL and Joint Commission performance measures (pressure ulcer prevention, accidental puncture monitoring, smoking cessation/flu immunization documentation)
 - Led initiative to improve veterans access to care through decreased surgery clinic no shows, with more than 50% reduction in clinic no shows
 - Develop, monitor and assess quality and efficiency measures and initiatives for the General Surgery Section
 - Monitor, analyze and assess surgical outcomes for the General Surgery Section
 - Review Quality Improvement tools and surveys
 - Collaborate with other section chiefs (Anesthesiology, ENT, General Surgery, ENT, Neurosurgery, Ophthalmology, Orthopedics, Podiatry, Urology, Vascular and Thoracic Surgery) to assess needs for a collaborative, comprehensive surgical care
- 2014-2016 Director, Surgical Services Grand Rounds Lecture Series, OBVAMC
- Developed a now CME accredited academic curriculum for this Grand Rounds Lecture Series; recruited local and national speakers
 - Incorporated telecommunication to broadcast Grand Rounds Lectures remotely, available to outlying VA Community Based Outpatient Clinics (CBOCs) in Louisiana and Texas and also to employee's computer desktops to allow greater educational reach
- 2016- Associate Professor, Department of Surgery
Louisiana State University New Orleans (offer letter signed, pending finalization)
- 2014-2016 Assistant Professor, Department of Surgery
Louisiana State University Shreveport
- 2014-2016 Staff Surgeon, Overton Brooks Veterans Affairs Medical Center (OBVAMC)
- 2014-2015 Consultant, Parkland Center for Clinical Innovation
Consultant on surgical site infection risk prediction modeling

LEADERSHIP/HEALTHCARE POLICY TRAINING & EXPERIENCE:

American College of Surgeons Health Policy Award <i>"Leadership Program in Health Policy and Management" Executive Education Program at Brandeis University Heller School for Social Policy and Management.</i>	June 12-18, 2016
American Medical Association Campaign School <i>Training in healthcare policy, legislation and politics in Washington, D.C.</i>	2013
American College of Surgeons Advocacy Grant	2012
Robert Wood Johnson Clinical Scholar, Yale University School of Medicine <i>Fellowship in healthcare policy & management, public health and research.</i>	2007 2009
Healthcare Policy Synergy Workshop, Institute of Medicine, Washington, D.C. <i>Healthcare policy training, development of health disparities proposal</i>	2008
Robert Wood Johnson Foundation Cover the Uninsured Week Oregon Committee <i>Organized symposium on the uninsured in Oregon, speaker Governor Kitzhaber</i>	2003
American Academy of Family Physicians National Congress <i>Authored resolution on "Presentation of the AAFP Universal Health Care Coverage Task Force Report and Inclusion of Resident and Student Feedback</i>	2000
Kaiser Family Foundation Barbara Jordan Health Policy Scholar <i>Worked in Washington DC office of US Senator Tom Harkin. Wrote speeches on The Breast & Cervical Cancer Treatment Act and Re-authorization of the Older Americans Act, attended hearings, wrote briefs on prescription drug coverage, coverage for experimental studies, and healthcare instrument safety.</i>	2000

HEALTH POLICY PANELS/KEY NOTE SPEAKER/PRESENTATIONS

The Louisiana Story: Tackling Preterm Birth through Collaboration and Innovation <i>CMS Quality Conference, Baltimore, MD</i>	Dec 2016
Achieving Viral Load Suppression through Collaboration – The Louisiana Story <i>HIV Affinity Group National Conference, Washington DC</i>	Dec 2016
Medicaid Expansion and Access to Healthcare: Learning from Louisiana <i>Louisiana Public Health Institute</i>	Dec 2016
Panel Member: Bridging the Gap Between Health Care and Health Equity <i>National Academy for State Health Policy, Pittsburgh, PA</i>	Oct 2016
HIV Affinity – The Louisiana Story <i>HIV Health Improvement Affinity Group National Webinar</i>	Nov 2016
Medicaid Industry Who's Who Series, "Mostly Medicaid" <i>State Spotlight Series: Achieving Healthcare Quality</i>	Sept 2016
Medicaid Expansion and Improving Healthcare Quality in Louisiana <i>American Association on Intellectual & Developmental Disabilities, Alexandria, LA</i>	Sept 2016
Panel Member: Using National Data Sources to Understand Healthcare Quality, Access and Disparities Among Women <i>AcademyHealth 2015 Annual Research Meeting, Minneapolis, Minnesota</i>	2015
Panel Member: Emerging Issues in Gender-Based and Women's Health. <i>AcademyHealth 2009 Annual Research Meeting, Chicago, Illinois.</i>	2009
Moderator, Robert Wood Johnson Alumni Careers in Health Policy.	2008

Robert Wood Johnson Clinical Scholars National Conference, Washington, D.C.
 Panel Member: The Many Avenues to Pursuing a Career in Health Policy. 2007
Barbara Jordan Health Policy Scholars Conference, Washington, D.C.

TOWN HALLS

Town Hall Meeting August 2016
Flood Recovery, Mold and Tetanus Vaccination, Mental Health Crisis Hotline
 Town Hall Meeting August 2016
Flood Recovery, Prescription Co-Pay Waivers, Early Refills for Prescriptions
 Rotary Club of Shreveport July 2016
Key Note Speaker: Medicaid Expansion
 Shreveport Medical Society July 2016
Key Note Speaker: Medicaid Expansion

COMMITTEE SERVICE AND ORGANIZATIONS

National Quality Forum 2016-present
Medicaid Innovation Accelerator Committee
 Alliance for a Healthier Generation 2016-present
Obesity Prevention Task Force
 Comparing Outcomes of Drugs and Appendectomy (CODA) 2016-present
National Stakeholder Advisory Board
 National Academy for State Health Policy 2016-present
Public and Population Health Advisory Group
 AcademyHealth 2016-present
State Health Research and Policy Interest Group Advisory Committee
 American College of Surgeons 2016-2019
Committee on Diversity Issues
 Robert Wood Johnson Foundation Clinical Scholars Alumni Association 2016-2018
Co-President
 Chair, Medicaid Quality Committee 2016-present
 Louisiana Commission on HIV, AIDS and Hep C 2016-present
Office of Public Health designee, appointed by Governor Edwards
 Louisiana Task Force on Telehealth Access 2016-present
Appointed by Secretary
 Executive Committee, Medicaid Evidence-based Decisions Project, Portland, OR 2016-present
 Chair, Improving Veterans Access to Care Committee 2015
 Board Member, Quality, Safety and Value Board, OBVAMC 2015-2016
 Chair, Systems Redesign Committee, OBVAMC 2015-2016
 Chair, General Surgery Faculty Recruitment Committee, OBVAMC 2015-2016
 Federation of State Medical Boards (FSMB) 2015-2016
Appointed Representative to Accreditation Council for Continuing Medical Education Accreditation Review Committee (review accreditation for CME)
 National Board of Medical Examiners (NBME) 2011 – 2015
NBME Board Member

Appointed by American Medical Association as one of 80 Board Members governing the NBME, overseeing a \$100 million annual budget that governs the USMLE, the Post-Licensure Assessment System, and works with specialty boards to protect the public health.

NBME Diversity and Inclusion Task Force	2013 – 2015
<i>Tasked to improve diversity and inclusion in the executive leadership of the NBME and the USMLE exam contents.</i>	
Association for Academic Surgery	
<i>Membership Committee</i>	2013 – 2015
<i>Information and Technology Committee</i>	2010 – 2012
<i>Program Committee</i>	2016 – present
Association of Women Surgeons, Communications Committee, Vice-Chair	2012 – 2014
Medical Society of Milwaukee County, Board of Directors	2012 – 2014
American Medical Association	
<i>Chair, Wisconsin Resident & Fellow Governing Council</i>	2011 – 2013
<i>AMA Surgical Caucus, Executive Committee</i>	2010 – 2011
<i>Wisconsin Medical Society, AMA Resident Delegate</i>	2010 – 2011
Robert Wood Johnson Clinical Scholars National Conference, Planning Committee	2008
Oregon Health & Science University Medical School First Year, Class President	2000 - 2001
Habitat for Humanity, Oregon State University Campus Chapter President	1988-1999
Science Student Council, President	1997-1998
Phi Eta Sigma National Honor Society, Oregon State University Chapter President	1997-1998
Oregon State University Undergraduate Senate, Senator	1997-1998
Talons Women's Leadership & Service Honorary Society, Vice-President	1997-1998
Medical Careers Explorer Scouts, Corvallis Chapter President	1995-1996

PEER-REVIEWED PUBLICATIONS

1. **Kuy S, Romero R.** Eliminating Critical Incident Tracking Network Patient Safety Events at a Veterans Affairs Institution through Crew Resource Management Training. *American Journal of Medical Quality. In Press.*
2. **Kuy S, Romero R.** Improving Staff Perception of a Safety Climate with Crew Resource Management Training. *Journal of Surgical Research. In Press*
3. **Kuy S.** Rapidly Growing, Bleeding Mass on a Golfer's Back. *JAMA Surgery. In Press*
4. **Kuy S, Romero R, Rose K, Vincent L.** Perineal Pain and Malodorous Drainage in a Rectal Cancer Patient. *BMJ Postgraduate Medical Journal. In Press*
5. **Koo D, Kuy S, Ogunleye A, Sangji N.** A Tradition of Advocacy in the American College of Surgeons: Protecting our patients, advancing our profession. *Bull Am Coll Surg. In Press*
6. **Eskander M, Neuwirth M, Kuy S, Keshava H, Meizoso J.** Technology for Teaching: New Tools for 21st Century Surgeons. *Bull Am Coll Surg. In Press*
7. **Kuy S, Dua A, Rieland J, Cronin D.** Cavernous Transformation of the Portal Vein. *Journal of Vascular Surgery.* 2016 Feb;63(2):529.
8. **Kuy S, Jenkins P, Romero R, Samra N, Kuy S.** The Rising Incidence and Mortality of Clostridium Difficile Associated Megacolon. *JAMA Surgery.* 2015 Oct 7:1-2.
9. **Kuy S, Romero R, Kuy S.** Gas Gangrene in a Diabetic Foot. *Journal of the Louisiana State Medical Society.* 2015 Sep-Oct;167(5):213-214. Epub 2015 Oct 15.

10. **Kuy S.** Carotid Body Tumor. *Journal of the Louisiana State Medical Society.* 2015 Jul-Aug;167(4):165. Epub 2015 Aug 15.
11. Busch K, Keshava H, **Kuy S**, Nezgoda J, Picou A. Teaching in the Operating Room: New Lessons for Training Surgical Residents. *Bull Am Coll Surg.* 2015 Aug;100(8):29-34.
12. Ogunleye A, Bliss L, **Kuy S**, Leichtle S. Political Advocacy in Surgery: The Case for Individual Engagement. *Bull Am Coll Surg.* 2015 Aug;100(8):40-4.
13. Dua A, **Kuy S**, Desai S, Heller J, Lee C. Diagnosis and Management of a Ruptured Mycotic Popliteal Pseudoaneurysm. *Vascular.* 2015 Aug;23(4):419-21
14. **Kuy S**, Dua A. Uncertainty in management of carotid stenosis in women – reply. *JAMA Surgery.* 2014;149(4):402-3.
15. **Kuy S**, Dua A, Desai S, Chappidi Rohit, Patel B, Seabrook G, Brown K, Lewis B, Rossi P, Lee C. The Increasing Incidence of Thromboembolic Events among Hospitalized Patients with Inflammatory Bowel Disease. *Vascular.* 2014 Jul 1.pii: 1708538114541799.
16. **Kuy S**, Dua A, Lee C, Patel B, Desai S, Dua A, Szabo A, Patel P. National Trends in Utilization of IVC Filters in the United States, 2000-2009. *Journal of Vascular Surgery: Venous and Lymphatic Disorders.* 2014 Jan;2(1):15-20.
17. Dua A, **Kuy S**, Lee CJ, Upchurch G Jr, Desai S. Epidemiology of Aortic Aneurysm Repair in the United States from 2000 to 2010. *Journal of Vascular Surgery.* 2014;59(6):1512-7.
18. Dua A, McMaster J, Desai P, Desai S, **Kuy S**, Mata M, Cooper J. The Association between Blunt Cardiac Injury and Isolated Sternal Fracture. *Journal of Cardiology Research and Practice.* 2014;2014:629687
19. Dua A, Dua A, Jechow S, Desai S, **Kuy S**. Idiopathic Spontaneous Rupture of an Intercostal Artery. *Wisconsin Medical Journal.* 2014;113(3):116-8.
20. Dua A, Aziz A, Desai S, McMaster J, **Kuy S**. National Trends in the Adoption of Laparoscopic Cholecystectomy over 7 years in the United States and Impact of Laparoscopic Approaches Stratified by Age. *Minimally Invasive Surgery.* 2014;2014:635461.
21. **Kuy S**, Juern J, Weigelt J. Laparoscopic Primary Repair of Traumatic Intrapericardial Diaphragmatic Hernia. *Journal of Laparoscopic Surgeons* 2014;18(2):333-7.
22. **Kuy S**, Dua A, Rossi P, Seabrook G, Lewis B, Patel B, Lee C, Desai S, Brown K. Carotid Endarterectomy National Trends Over a Decade: Does gender matter? *Annals of Vascular Surgery.* 2013 Dec 6. pii: S0890-5096(13)00641-9.
23. Dua A, Desai SS, Dua A, Charlton-Ouw K, Dongerkery SP, Patel B, **Kuy S**, McMaster J, Darlow M, Shapiro ML. The Impact of Co-Morbid Conditions and Insurance Status on Trauma Patient Outcomes. *TRAUMA.* 2013, Vol. 15 Issue 3, p239
24. **Kuy S**, Rossi P, Seabrook G, Brown K, Lewis B, Rilling W, Martin G, Patel B, Dua A, McMaster J, Desai S, Lee C. Endovascular Management of a Traumatic Renal-Caval Arteriovenous Fistula in a Pediatric Patient. *Annals of Vascular Surgery.* Dec 2013. pii: S0890-5096(13)00472-X.
25. **Kuy S**, Dua A, Desai S, Dua A, Patel B, Tondravi N, Seabrook G, Brown K, Lewis B, Lee C, **Kuy S**, Subbarayan R, Rossi P. Surgical Site Infections Following Lower Extremity Revascularization Procedures Involving Groin Incisions. *Annals of Vascular Surgery.* 2013 Nov 1. doi:pii: S0890-5096(13)00423-8.
26. Dua A, Dua A, Desai S, **Kuy S**, Sharma R, Jechow S, McMaster J, Patel B, **Kuy S**. Gender Based Differences in Management and Outcomes of Cholecystitis. *American Journal of Surgery.* 2013 Nov;206(5):641-6.
27. **Kuy S**, He C, Cronin D. Renal Mucormycosis: A Rare and Potentially Lethal Complication of Kidney Transplantation. *Case Reports in Transplantation.* October 2013;2013:915423

28. McMaster J, Dua A, Desai S, **Kuy S**. Short Term Outcomes Following Breast Cancer Surgery in Pregnant Women. *Gynecologic Oncology*. 2013 Sep 13. doi:pii: S0090-8258(13)01177-3.
29. Kulaylat AN, Zheng F, **Kuy S**, Bittner JG. Early Surgical Specialization: a new paradigm. *Bull Am Coll Surg*. 2013 Aug;98(8):43-9.
30. Baker J, Misra S, Manimala NJ, **Kuy S**, Gantt G. The Role of Politics in Shaping Surgical Training. *Bull Am Coll Surg*. 2013 Aug;98(8):17-25..
31. **Kuy S**, Seabrook G, Rossi P, Lewis B, Dua A, Brown K. Management of Carotid Stenosis in Women. *JAMA Surgery*. 2013 Aug;148(8):788-90. Epub June 26, 2013.
32. Dua A, Patel B, **Kuy S**, Seabrook G, Tondravi N, Brown K, Lewis B, Rossi P. Asymptomatic 50-75% Internal Carotid Artery Stenosis in 288 Patients: Risk Factors for Disease Progression and Ipsilateral Neurological Symptoms. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013 Dec; 24(4):165-70. doi: 10.1177/1531003513491986.
33. Dua A, Patel B, Heller J, **Kuy S**, Dubose J, Tomasek JS, Larssen EM, Desai S. Variability in the Management of Superficial Venous Thrombophlebitis between Phlebologists and Vascular Surgeons. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013 Jun;25(1-2):5-10.
34. Desai P, Dua A, McMaster J, Patel B, Dua A, **Kuy S**, Desai S, Krzowski-Firych J. Infectious Mononucleosis-Like Syndrome Presented in Toxoplasmosis Infection. *J Surg Rad*. 2013;134-136.
35. **Kuy S**, Vickery M, Dua A, Rosner G. Appendiceal endometriosis mimicking appendicitis. *JAMA Surgery*. 2013 May 1;148(5):481.
36. **Kuy S**, Somberg L, Paul J, Brown N, Saving A, Codner P. Undetected Penetrating Bladder Injuries Presenting as a Spontaneously Expulsed Bullet During Voiding: A Rare Entity and Review of the Literature. *Journal of Emergency Medicine*. 2013 May 25: S0736-4679(13)00356-9.
37. Dua A, Desai S, **Kuy S**, Patel B, Dua A, Desai P, Darlow M, Shirqavi J, Charlton-Ouw K, Shortell C. Predicting outcomes using the national trauma data bank: Optimum management of traumatic and blunt thoracic injury. *Perspectives in Vascular Surgery and Endovascular Therapy*. Sep;24(3):123-127, ePub: March 26, 2013.
38. **Kuy S**, Dua A, Desai SS, Baraniewski H, Lee C. Ruptured Mycobacterial Aneurysm of the Carotid Artery. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013;25(3-4):53-6.
39. Dua A, Desai S, McMaster J, Aziz A, Dua A, **Kuy S**. The Role of Platelets in Vascular Trauma Patients Compared to Patients with Chronic Vascular Disease. *Vascular Disease Management*. 2013;10(11):E240-E243.
40. **Kuy S**, Codner P, Guralnick M, Dua A, Paul J. Combined rectovesicular injuries from low velocity penetrating trauma in an adult. *Wisc Med J*. 2013;112(1):32-34.
41. **Kuy S**, Greenberg C, Gusani N, Dimick J, Kao L, Brasel K. Health services research resources for surgeons. *J Surg Res*. 2011;171(1):e69-73.
42. **Kuy S**, Sosa J, Desai R, Roman S, Rosenthal R. Age matters: A study of clinical and economic outcomes following cholecystectomy in elderly Americans. *Am J Surg*. 2011;201(6): 789-796.
43. **Kuy S**, Roman SA, Desai R, Sosa JA. Outcomes Following Cholecystectomy in Pregnant and Non-pregnant Women. *Surgery*. 2009;146(2):358-366.
44. **Kuy S**, Roman S, Desai R, Sosa J. Outcomes following thyroid and parathyroid surgery in pregnant women. *Arch Surg*. 2009;144(5):399-406. Commentary by F Moore.
45. **Kuy S**. Stand up for patients. *Bull Am Coll Surg*. 2008;93(8):23-24.
46. Franks K, Li H, **Kuy S**, Kong W. Photodissociation of ICN at 266 nm and BrCN at 230 nm using brute force orientation. *Chemical Physics Letters*. 1999;302:151-156.

EDITORIALS/TECHNICAL NOTES/NEWSLETTER ARTICLES/MEDICAL BLOGS

1. **Kuy S**, Romero R, Cypher E. Shreveport: A Success Story. Creating a Culture of Safety at the Overton Brooks VA Medical Center. *Topics in Patient Safety. Veterans Affairs National Center for Patient Safety*. September 2014;14(5):1,4.
2. **Kuy S**. Profiles in Leadership. *Association of Women Surgeons Blog*. September 2014.
3. **Kuy S**. Health Services Research for Surgeons. *Association of Women Surgeons Website*. 2014.
4. **Kuy S**. Women Surgeon Leaders for the 21st Century. *Association of Women Surgeons Newsletter*. July 25, 2014
5. **Kuy S**. The Imperative to Improve Gallbladder Disease Treatment and Outcomes for Men. *Robert Wood Johnson Foundation Human Capitol Blog*. November 22, 2013.
6. **Kuy S**. Society for Vascular Surgery Trainee Advocacy Award Essay. *Society for Vascular Surgery website*. 2012.
7. **Kuy S**. Information & technology review: Online health resources for surgeons. *Association for Academic Surgery Newsletter*. Fall, 2010:6-7.
8. **Kuy S**. Stand up for patients. *Los Angeles Times*. February 28, 2008.

BOOKS AND BOOK CHAPTERS

1. **Kuy S** (senior editor), Kwon R, Hochman M. 50 Studies Every Surgeon Should Know. Oxford Press. (Planned release 2016)
2. Provo B, **Kuy S**. Venous insufficiency ulcers. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2015, Philadelphia: Lippincott Williams and Wilkins.
3. Aljoudi M, Dua A, **Kuy S**. Cervical Bruit. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
4. Dua A, Aljoudi M, **Kuy S**. Absent or Diminished Pulse. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
1. Aljoudi M, McMaster J, **Kuy S**. Breast Cancer and Pregnancy. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
2. Dua A, Desai S, **Kuy S**. Inguinal Mass. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.

PRESENTATIONS

1. Reducing Surgery Cancellations in a Tertiary Hospital: A Three Year Review. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
2. Why We Don't Come to Clinic: Patient Perspectives. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.

3. The Myth of Sisyphus: Is Reducing Surgery Clinic No-Shows Impossible? Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
4. It Takes a Village: Referring Providers Impact Patient No Shows. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
5. Reducing Surgical Site Infections Utilizing a Prevention Bundle and a Multidisciplinary Approach at a Veterans Affairs Hospital. The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
6. Transformational Change: Creating a Culture of Safety in the Operating Room. Presented at: The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
7. Outlier to Leader: Designing a Risk Stratification Intervention to Decrease 30 Day Surgical Mortality in a Veterans Affairs Hospital. The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
8. Outlier to Leader: Designing a Risk Stratification Intervention to Decrease 30 Day Surgical Mortality in a Veterans Affairs Hospital. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
9. Transformational Change: Creating a Culture of Safety in the Operating Room. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
10. The Rising Incidence and Mortality of Clostridium Difficile Associated Megacolon. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
11. The Increasing Incidence of Thromboembolic Events Among Patients with Inflammatory Bowel Disease. Presented at: American College of Surgeons 2013 Clinical Congress; Washington DC; October 2013.
12. Diagnosis and Management of a Ruptured Popliteal Mycotic Pseudoaneurysm. Presented at: Eastern Vascular Society. Sulfur Springs, West Virginia. September 21, 2013. (First Place Winner of the 2013 Resident Award)
13. Ruptured Carotid Mycotic Tuberculoid Aneurysm from Intravesical BCG. Presented at: Midwestern Vascular Surgical Society. Chicago, Illinois; September 8, 2013
14. Do women experience delays in carotid endarterectomy? Presented at: Society for Vascular Surgery Annual Meeting; San Francisco, California; May 31, 2013. (Winner of Sectional Poster Competition)
15. National trends in utilization of IVC filters over a decade in the United States, 2000-2009. Presented at: Society for Vascular Surgery Annual Meeting; San Francisco, California; May 31, 2013.
16. Surgical site infections and complications following vascular groin procedures. Presented at: Peripheral Vascular Surgery Society meeting; Park City, Utah; February 1, 2013.
17. Endovascular management of a traumatic renal-caval arteriovenous fistula in a pediatric patient. Presented at: International Symposium on Endovascular Therapy; Miami, Florida; January 22, 2013.
18. Carotid endarterectomy national trends over a decade: Does gender matter? Presented at: Midwestern Vascular Surgery annual meeting; Milwaukee, Wisconsin; September 6, 2012.
19. Asymptomatic 50-75% internal carotid artery stenosis in 288 patients: Risk factors for disease progression and ipsilateral neurological symptoms. Presented at: Midwestern Vascular Surgery annual meeting; Milwaukee, Wisconsin; September 6, 2012.

20. A study of clinical and economic outcomes following cholecystectomy in elderly Americans. Presented at: Department of Surgery grand rounds, Medical College of Wisconsin; Milwaukee, Wisconsin; June 10, 2010.
21. Predictors of in-hospital mortality following cholecystectomy among hospitalized patients. Presented at: 5th annual Academic Surgical Congress; San Antonio, Texas; February 3, 2010.
22. Predictors of in-hospital mortality following cholecystectomy. Presented at: American Medical Association 2010 research symposium; San Diego, California; November 5, 2010 (Honorable Mention Prize).
23. Outcomes following breast surgery in pregnant women. Presented at: 90th annual meeting of the New England Surgical Society; Newport, Rhode Island; September 13, 2009.
24. Outcomes following breast surgery in pregnant women. Presented at: Department of Surgery grand rounds, Yale University School of Medicine; New Haven, Connecticut; September 9, 2009.
25. Gender based differences in management and outcomes of cholecystitis. Presented at: AcademyHealth 2009 annual research meeting; Chicago, Illinois; June 28, 2009.
26. Gender based disparities in outcomes of cholecystitis. Presented at: New England science symposium; Boston, Massachusetts; April 3, 2009.
27. Women have better outcomes in cholecystitis. Presented at: American Medical Women's Association conference, Women's Health 2009, 17th Annual Congress; Williamsburg, Virginia; March 27-29, 2009.
28. Outcomes following cholecystectomy in pregnant and non-pregnant women. Presented at: 4th Annual Academic Surgical Congress; Fort Myers, Florida; February 3-6, 2009.
29. Outcomes following thyroid and parathyroid surgery in pregnant women. Presented at: Robert Wood Johnson Clinical Scholars 2008 National Conference; Washington, D.C.; November 18-21, 2008.
30. Disparities in outcomes following thyroid and parathyroid surgery in pregnant and non-pregnant women. Presented at: Disparities in Surgical Care symposium; Boston, Massachusetts; Oct 27-28, 2008.
31. Outcomes following thyroidectomy and parathyroidectomy in pregnant women in the US, 1999-2005. Presented at: 89th annual meeting of the New England Surgical Society; Boston, Massachusetts; September 26-28, 2008.
32. Outcomes following thyroid and parathyroid surgery in pregnant women. Presented at: Department of Surgery grand rounds, Yale University School of Medicine; New Haven, Connecticut; September 24, 2008.
33. Are Drains Necessary After Craniostomosis Surgery? American Society of Plastic Surgeons: Plastic Surgery Senior Residents Conference. Houston, Texas. March 17-19, 2005.
34. The Effects of Heat Treatment on Lactoferrin Concentration in Breast Milk. International Health Medical Education Consortium Conference. Havana, Cuba. March 12-15, 2002.

JOURNAL REVIEWER
JAMA Surgery Reviewer

2016-present

<i>Journal of Surgical Research</i> Reviewer	2016-present
<i>Alexandria Journal of Medicine</i> Reviewer	2016-present
<i>British Medical Journal Case Reports</i> Reviewer	2014-present

TEACHING EXPERIENCE:

Louisiana State University – Shreveport, Assistant Professor of Surgery	2014-present
Lecturer, Surgery Resident SCORE Curriculum	2016
Lecturer, Third Year Medical Student Curriculum	2014-2016
Clinical Preceptor, First Year Medical Students	2014-2016
Yale University School of Medicine	
Course Facilitator, Introduction to Research	2007 – 2009
Oregon State University	
Teaching Assistant, General Microbiology	1999
Teaching Assistant, Introduction to Microbiology	1998 – 1999
Teaching Assistant, Biology	1997

HONORS, AWARDS & GRANTS

American College of Surgeons Health Policy Scholar <i>Award provides \$8,000 grant, one of two general surgeons awarded to attend the “Leadership Program in Health Policy and Management” Executive Education Program at Brandeis University Heller School for Social Policy and Management.</i>	2016
National Governors Association <i>Awarded to Louisiana Medicaid’s Health Information Technology Team, one of three states to receive this award and become part of the “Getting the Right Information to the Right Health Care Providers, at the Right Time- How States Can Improve Data Flow” Technical Assistance program.</i>	2016
Zero to Three <i>\$10,000 grant for Technical Assistance implementing Text4Baby, a program aimed at improving birth outcomes for pregnant women in Louisiana Medicaid.</i>	2016
Business Report’s 2016 “Forty Under 40” Award	2016
Ford Family Foundation Gerald E. Bruce Leadership & Community Service Award <i>Award provides \$5,000 grant, recognizing excellence in leadership & service.</i>	2016
Certificate of Appreciation, Overton Brooks VA Medical Center <i>Presented by Medical Center Director for work in promoting diversity, invited Keynote Speaker for VA’s Asian Pacific American Celebration Month</i>	2015

Making a Difference Award, Overton Brooks VA Medical Center <i>Recognition of excellence in clinical care</i>	2014
Certificate of Appreciation, Overton Brooks VA Medical Center <i>Presented by Medical Center Director for Surgical Services' Achievement in Reducing Adverse Events and Mortality</i>	2014
American College of Surgeons Advocacy Travel Grant	2012
American Medical Association 2010 Research Symposium Honorable Mention Prize	2010
Medical College of Wisconsin Affiliated Hospitals (MCWAH) Research Award	2010
New England Surgical Society 89 th Annual Resident Research Competition Award	2008
Robert Wood Johnson Foundation Clinical Scholars Fellowship. National award providing two years of training in health services research, Yale University School of Medicine	2007 2009
Surgery Intern of the Year Award, Department of Surgery, University of Texas Health Sciences Center at San Antonio	2006
Oregon Health & Science University ROSE Award (Recognition of Outstanding Service and Excellence)	2001
Ralph Bosworth, MD Memorial Scholarship	2000
Dr. JoAnne J. Trow Woman of Distinction Award	2000
Waldo-Cummings Outstanding Student Award	2000
Phi Kappa Phi Honor Society Tunison Award	1999
OSU Department of Microbiology Mark H. MiddleKauf Scholarship	1999
OSU Department of Microbiology Joseph E. Simmons Scholarship	1999
OSU College of Agricultural Science Jesse Hanson Scholarship	1999
OSU College of Science Heitmeyer Scholarship	1996
Presidential Scholar	1996
Laurel G. Case, MD Memorial Scholarship	1996

Robert C. Byrd Honors Scholar

1996

Valedictorian, Crescent Valley High School

1996

REFERENCES

(b) (6) [Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]

(b) (6) [Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]

(b) (6) [Redacted]
[Redacted]
[Redacted]
[Redacted]

(b) (6) [Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]

SreyRam Kuy, MD, MHS, is Chief Medical Officer for Medicaid in the Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr. Kuy leads the drive for improving healthcare quality, promoting cost effectiveness and increasing health information technology adoption in a \$7.5 billion health system serving 1.6 million patients. Under her leadership, Louisiana Medicaid was the first state to develop a Zika prevention strategy for pregnant Medicaid patients; enabled women with breast cancer to have access to needed reconstructive surgery and BRCA testing, led efforts to coordinate medical disaster relief efforts during Louisiana's Great Flood, and is leading Louisiana Medicaid's initiative to tackle the opioid epidemic. She has developed state wide health performance metrics, pay for performance incentives, and established novel "Medicaid Expansion Early Wins measures" which enable the state of Louisiana to assess how Medicaid expansion directly impacts lives.

Prior to serving as Chief Medical Officer for Louisiana Medicaid, Dr. Kuy has served in numerous leadership roles, including Director of the Center for Innovations in Quality, Outcomes and Patient Safety, Assistant Chief of General Surgery, Chair of the Systems Redesign Committee, and on the Quality, Safety & Value Board at Overton Brooks VA Medical Center. Dr. Kuy's work successfully reducing patient mortality & morbidity and decreasing adverse safety events was profiled by the VA National Center for Patient Safety. Her work increasing veterans' access to care through clinic efficiency was profiled by the Association for VA Surgeons, and templates she developed were disseminated for implementation at VA medical centers across the country. Dr. Kuy is deeply committed to caring for our veterans, and has more than a decade of experience serving in VA systems across the country in Oregon, Texas, Connecticut, Wisconsin and Louisiana.

Dr. Kuy grew up in Oregon, graduated as Valedictorian from Crescent Valley High School, and attended Oregon State University where she earned dual degrees in Philosophy and Microbiology. She attended medical school at Oregon Health & Sciences University, then finished general surgery residency. Dr. Kuy earned her master's degree in health policy, public health and outcomes research at Yale University School of Medicine as a Robert Wood Johnson Clinical Scholar. She worked as a Kaiser Family Foundation Health Policy Scholar in the US Senate in Washington DC.

Dr. Kuy has served in state and national leadership roles in healthcare and health policy. She served as a Board Member on the National Board of Medical Examiners and the Federation of State Medical Boards' representative on the Accreditation Council for Continuing Medical Education. Dr. Kuy has served on several national committees on healthcare policy, quality and safety, including the AcademyHealth State Health Research and Policy Interest Group Advisory Committee, National Quality Forum Medicaid Innovation Accelerator Committee, Alliance for a Healthier Generation's Obesity Prevention Task Force, Commission on HIV, AIDS and Hep C, Taskforce on Telehealth, Commission on Opioids, and the American College of Surgeons' Diversity Committee. Dr. Kuy has published more than 40 articles in JAMA Surgery, Surgery, American Journal of Surgery and other medical journals on healthcare quality and patient safety. Her textbook, "Fifty Studies Every Surgeon Should Know", will be released by Oxford University Press. She has also written for the Los Angeles Times, USA Today, Washington Post, The Independent, Salon and the Huffington Post. Dr. Kuy received Business Report's 40 Under 40 Award in 2016 for her work to improve healthcare quality in the Louisiana Medicaid population and the Ford Foundation's Gerald E. Bruce Community Service Award for her work serving veterans.

Read about Dr. Kuy's work reducing mortality and patient safety adverse events profiled in the VA National Center for Patient Safety here:

http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp

Read about Dr. Kuy's work improving veterans' access to care through clinic efficiency profiled by the Association of VA Surgeons here: <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NOSHOWS>

Read about Dr. Kuy's work at Louisiana Medicaid improving healthcare quality profiled by Mostly Medicaid here: <http://www.mostlymedicaid.com/?p=1821>

Read about Dr. Kuy's work with Medicaid Expansion to improve patient health profiled by Business Reports 40 Under 40 here: <https://www.businessreport.com/article/forty-40-qa-sreyram-kuy>



VA National Center for Patient Safety

Shreveport: A Success Story

“Hats off to the Overton Brooks surgical service. You are an inspiration to me and your other VHA colleagues and a reminder of why we work here.”

-Douglas Paull, MD, VA National Center for Patient Safety



A pre-procedure briefing with the surgical team helps to identify problems early on and prevents surgical errors. From left: Kristy Kraker, surgical technician, CRNA; Ellis “Bubba” Maxwell; Barbara Fanta, circulating nurse; SreyRam Kuy, surgeon

Tuesday, August 26, 2014

At the Overton Brooks VA Medical Center, we have made a concerted effort over the past year to not just improve, but excel at being a safe and high-quality surgical service. As a result, we have made tremendous strides in changing the culture of our surgical service. A year ago, we embarked on this

journey, starting with a Clinical Team Training (CTT) session led by Douglas Paull, M.D., director of NCPS' patient safety curriculum and medical simulation program.

"The Overton Brooks surgical service story demonstrates that patient safety can serve as a rallying theme to provide joy, meaning and success in our daily work in caring for Veterans," said Dr. Paull. "The story has heroes, including transformational leaders and staff who embraced change and implemented a new framework, Crew Resource Management – CRM – to improve teamwork and communication, staff morale, and patient outcomes."



Pre-procedure briefings allow the team to identify needed supplies and answer questions, preventing delays and "wasted" minutes in the OR. From left: Stephani Bordelin Frost, CRNA student; Barbara Fanta, circulating nurse; Aras Emdadi, surgery resident; SreyRam Kuy, attending surgeon. Two team members present, but not in the photo: Joseph Zachary, chief surgery resident; Burt Smith, CRNA.

We came full circle when our second CTT session was held with Dr. Paull, June 18, 2014. Using both observational and survey data, via the Kirkpatrick Learning Model, we found that over the course of this past year our surgical service team members have significantly improved our communication skills, applying CRM principles and techniques to our daily work in the OR, as noted by Dr. Paull. Using a multi-pronged approach, we have implemented pre-procedure briefings, time-outs, post-procedure briefings, OR to PACU hand-offs (using a standardized template) and integrated situational awareness strategies/countermeasures into our culture.

During the initial training one year ago, we learned about CRM, which is a set of training procedures used in critical work environments where human error can have devastating effects. Because human beings are fallible, it is inevitable that mistakes will be made. The goal of CRM training is to overcome the fallibility of human teams, by implementing such things as situational strategies, pre-procedural briefings and post-procedural debriefings in the OR. CRM-based training has been used in high-risk fields, such as aviation to make air travel safer, fire fighter training, and the Navy and Marine Corps for maritime safety. In the field of health care, the OR is truly a place where a culture of safety and team communication is critically important.

When Dr. Paull and his team returned to teach another round of training courses in CTT, our workshops involved real problems that surgical services face daily across the country. One focused on identifying the obstacles and challenges to starting operations on time.

We used a "Fishbone" flow diagram to identify factors at the patient, personnel, process and organizational level. Everyone on the surgical service actively participated and were thoroughly engaged in the workshop, including but not limited to surgeons, scrub technicians, environmental management service staff, nursing staff, anesthesiologists and equipment sterilization staff.

The integration of CRM-based changes into our culture has been extremely fruitful, and we will retain the lessons learned as we continue to push ourselves to be even better. At the time of our second training session:

- 65 percent of our surgical service felt comfortable speaking up with concerns in their work area
- 70 percent of our surgical service self-identified as "apprentice/practitioners" or "experts in the crew resource management experience"

The majority of those in our surgical service felt that as a result of simulation scenarios held during the training sessions, they are more likely to conduct a checklist-guided briefing prior to an invasive procedure; also, when faced with a future challenge in patient care, the majority felt that they would be likely to use teamwork and communication strategies practiced in the simulation scenarios.

Scenarios practiced included managing an unexpected air embolism, preventing an operating room fire, and averting a wrong site surgery. We used techniques such as the "3-Ws," "4-Step Tool" and the "1-2-3 Rule"⁵ to learn effective communication, interaction and decision making. These techniques allow all surgical service team members to engage, speak up and bring critical information to the attention of the surgeons, to avert a potential adverse event and promote a culture of safety. In addition, the simulation scenarios used in our training effectively promoted briefings, as well as a structured approach to

teamwork and communication during a crisis. As a result, our surgical service team members performed with "good to excellent" skills in utilizing CRM techniques during simulated crisis scenarios; and feedback from our staff has been positive. All in all, over the course of the past year, our team members have significantly improved their mastery of teamwork and communication strategies because of the CTT training.

"Burt" Thomas Smith, a certified registered nurse anesthetist, stated that pre-operative briefings help identify problems before they happen, allowing changes in patient positioning to prevent adverse outcomes. "The surgeon will want the patient in prone position," Mr. Smith said, "This comes up in the pre-operative briefing and I'll say, 'Because of the patient's size, he can't be in that position for long. He'll breathe better in lithotomy.' Then the surgeon might say, 'Okay, I'll make it work in lithotomy.' We decide all of this before we even bring the patient back." "Or," Mr. Smith continued, "the surgeon might need a special lens for a cataract surgery, so the circulator makes sure we have it even before we bring the patient back." Cleveland Waterman, M.D., an anesthesiologist, said of pre-procedure briefings, "Oh, it's the best thing! It's brutally hard to ask questions, you ask the surgery resident a question and get one answer, then ask the surgery attending and get another answer. With pre-procedure briefings you get a consistent place to ask questions and get one answer."

The training also helped us decrease wasted OR minutes by identifying a number of pitfalls, such as a requirement for specialized equipment and challenges in patient positioning. Addressing misconceptions about patient care in the pre-op briefing, another pitfall we have overcome, enables the surgical team to quickly address misconceptions accurately, prior to the patient arriving in the OR. As our OR Nurse Manager Emily Cypher, said, "The pre-operative briefings really help!"

Overall, we found that implementing a fundamental change in the culture, using CRM techniques, has resulted in rapid improvements in our OR efficiency and surgical care, oftentimes within months of the implementation. For instance, from July 2013 to June 2014 we had a 100 percent rate of pre-procedure and post-procedure briefings. Reviewing our OR efficiency, we found that we had decreased "wasted" OR minutes, from as high as 1,030 minutes in January 2014 to 339 minutes in June 2014. We have also improved equipment availability, recording a 100 percent level of equipment availability from November 2013 to May 2014. In addition to improving our OR efficiency, we found that instituting a culture of safety through empowering surgical team members to speak up, using situational awareness strategies and countermeasures training, has had a profound impact on patient safety.

Since beginning CTT training, we have noted a significant decline in Critical Incident Tracking Network (CITN) events. In fiscal year 2013, three CITN events occurred: **In comparison, no CITN events have**

occurred to date this fiscal year. Prior research has demonstrated that successful implementation of patient safety tools like pre-procedure briefings and post-procedure debriefings is dependent upon facility specific leadership support.^{6, 7} At Overton Brooks, we have had the complete support of our surgical service chief, OR nurse manager, anesthesia chief and the entire senior facility leadership. We believe the success of our experience has been integrally linked to our leadership's commitment to changing the culture into one that emphasizes patient safety as our paramount concern. In addition, the sincere commitment of our entire surgical service team to creating a culture of safety is deep rooted, involving everyone at all levels. It is this team-wide commitment that has brought about what we call "The Shreveport Success Story." We are proud of our surgical service team for accomplishing this mission and serving our Veterans with the safest, highest quality care possible.

"Change in a vacuum is destined to fall by the wayside. Training, and recurrent training, such as advocated by the Overton Brooks model, and bolstered by leadership support, is capable of delivering on the CRM promise of high-reliability, safe, team-oriented, and patient-centered health care delivery," said Dr. Paull. **"Hats off to the Overton Brooks surgical service. You are an inspiration to me and your other VHA colleagues and a reminder of why we work here."**

Learn More

Read the entire article in the September/October edition of "Topics In Patient Safety"

file:///E:/USB%20DISK/Promotion%20and%20Tenure/VA%20Tips%20article%20September%202014.pdf

See more at: http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp#sthash.gDBST76l.dpuf



REDUCING NO SHOWS

May 16, 2016

Read the original Association of VA Surgeons article here: <http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS>

SreyRam Kuy, MD (Assistant Chief, General Surgery, The Overton Brooks VA Shreveport, LA) presented several papers centered around access improvement in clinic and the operating room:

- "Why we don't come to clinic: Patient perspectives"
- "It takes a village: referring providers impact patient no shows"
- "The myth of Sisyphus: is reducing surgery clinic no-shows impossible?"
- "Reducing Surgery Cancellations in a Tertiary Hospital: A Three-year review."

Can't make your appointment...

Save a spot, give a slot to your Battle Buddy

**Your slot is valuable
Do Not Be a No Show!**

Please call to reschedule your appointment if you are unable to keep it.

General Surgery and Vascular Surgery: 1-800-863-7441 ext 6438
Ophthalmology: 1-800-863-7441 ext 7411 or 7358
Other Clinics: 318-990-5000 or 1-800-644-8370

SreyRam Kuy, MD, MHS
Center for Innovations in Quality, Outcomes and Patient Safety
Surgical Service, Overton Brooks VA Medical Center

Missed opportunities in clinic and the operating room (OR) can account for significant overall inefficiencies in provision of access in the VA. Missed opportunities can vary widely by facility and service but nationally averages 12.3% for clinics (8-18% by surgery specialty) and 8.6% for the OR (8-13% by surgery specialty). (National Surgery Office Report FY16 Quarter 1) Over 50% of missed opportunities are due to patient-controllable factors such as last second cancellation or no-shows. Dr. Kuy's group presented data to suggest that a reduction missed opportunities by one-third could shift \$188 million annually towards other uses. That is, by occupying those slots with patients who show for their appointment, in lieu of having empty slots, patients and money should be diverted away from non-VA care.

Dr. Kuy revealed that at the start of their study in February 2015, their general surgery clinic had a monthly missed opportunity rate of 25%. After implementing her intervention, by February 2016, the general surgery clinic missed opportunity rate was reduced by over 50% to 10.8%.

Her success in reducing missed opportunity rates was due to a combination of having caring dedicated staff committed to the service of veterans, supportive leadership in our medical center, and a systems redesign approach driven by LEAN management strategies. They brought together veterans, clerks, nurses, technicians, physicians, and the leadership from the Surgical Service, the business office, and volunteer services to systematically determine the key factors contributing to patient missed opportunities, and then mapped these factors in a flow diagram. They presented a display of their process Systems Redesign-LEAN management assessment.

They next conducted a series of pilot studies to test these factors. One pilot study surveyed veterans who "no-showed" to clinic as to reasons for no-show. Another study reviewed the clinical indications for a surgical consult, referring provider factors, and demographics of patients who no-showed for the past six months in that clinic. Moving forward, they next designed a series of interventions, targeting patients, referring providers, and the clinic system. For patient interventions, they utilized the altruistic camaraderie shared by veterans, incorporating a slogan suggested by a veteran member of our systems redesign team, "Never leave a battle buddy behind". They created a veteran-centric slogan, "Save a Spot, Give a Slot to Your Battle Buddy!" and educated patients with "Save a Spot, Give a Slot to Your Battle Buddy!" themed clinic appointment notification letters, posters which were placed by elevators in the medical center, posted on the medical center's social media, throughout the clinic, at check-in and check-out sites by the clerks' desks, and in clinic rooms.

Next they targeted referring providers, by educating referring providers about the importance of informing patients about the consult placed, and revising their CPRS consults to include a mandatory check box verifying providers have communicated the need for the consult with their patient.

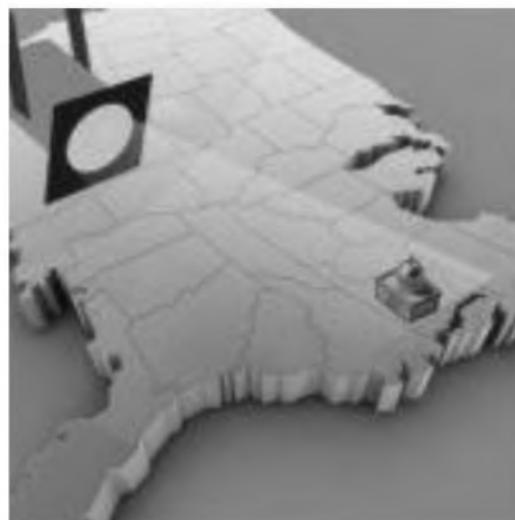
They also recruited volunteer services to assist with reducing patient no shows, enlisting volunteer help to make live calls to all clinic patients days before clinic, remind them of their appointment, and if any patients were identified as being unable to keep their appointment, a list of those patients were given to our clinic nurse manager to reschedule. As part of the discussion following her presentation, we suggested involving the VSOs in the goal of decreasing veteran no shows, avoiding overbooking when scheduling appointments.

Dr. Kuy concluded her presentations by emphasizing that by creating a culture of accountability, and tapping into this phenomenal sense of comradery among veterans absolutely a positive impact will be made on decreased clinic and OR cancellations, as well as improved on time OR first start rates.



State Spotlight: LA

We spoke with Dr. SreyRam Kuy, CMO of LA Medicaid. She provided a great view into the early success of the LA Medicaid expansion, as well as the vision for using Medicaid as a driving force for improving health outcomes in the state.



Learn More

Read the entire article in the September edition of Mostly Medicaid at:
<http://www.mostlymedicaid.com/?p=1821>

Watch Mostly Medicaid's "State Spotlight on Louisiana" video presentation by Dr. Kuy at: <http://www.mostlymedicaid.com/?p=1813>

Medicaid Industry Who's Who Series

SreyRam Kuy, MD, MHS

Medicaid Industry Who's Who: SreyRam Kuy, MD, MHS –
Chief Medical Officer, Louisiana Medicaid



1. Which segment of the Industry are you currently involved?

My work in healthcare has been fluid, moving between the patient bedside, the surgical suite and the board room. However, at the heart of it, I'm a surgeon with a passion for healthcare quality and vulnerable populations. As a surgeon I took care of veterans. It was such a privilege to care for veterans; the men and women who fought for the freedoms that we enjoy. Many of my patients struggled with PTSD, depression, substance abuse and poverty. However, they are such an extraordinary group; one of the favorite parts of my work as a surgeon was listening to the incredible stories my patients shared about courage, camaraderie and the concept of never leaving behind your fallen "battle buddy".

I've since transitioned from the operating room to the health policy arena, but these lessons that my patients taught remain with me. As we face the challenges of how to improve healthcare for our communities, our state and our country, it is only by having the courage to change the way we think that we can impact the direction of our future. It is courage that gives us clear eyes to embrace innovation and imagine beyond the reality of today.

Working in complex state level health policy, I see daily that camaraderie is collaboration crucial for accomplishing goals. Only by collaborating can we move the needle in health outcomes. Ultimately, we all have the same goal; to improve the health of people of our state. And bringing together all stakeholders' perspectives, from providers to plans, from medical centers to the individual patient, is critical to making a real change in the health of the whole state.

Last of all, my veterans taught me that in the heat of the battle, you never leave behind your fallen battle buddy. For me, never forgetting your fallen battle buddy means never leaving behind the most vulnerable populations of our community. In Louisiana, we've been ranked 50th in the country for

women's health, childhood poverty, and overall health of our people. We have one of the highest incidences of cancer, highest rates of incarceration and highest rates of sexually transmitted infections. Being one of poorest states in the country, these are extraordinary challenges to face. However, as we work to improve healthcare quality, we have to realize that to truly move the needle on health, the most vulnerable populations can't be left behind.

I truly do believe that with courage, collaboration, and the conviction to never forget our vulnerable populations, we can move towards a healthy community.

2. What is your current position and with what organization? How many years have you been in the Medicaid industry?

I currently serve as Chief Medical Officer for Louisiana Medicaid. This is my first year in Medicaid. I was appointed by Secretary Gee with the charge to improve the quality of healthcare for the state of Louisiana, develop a statewide HIT strategy that would help us achieve the vision of quality, transparency and accountability, and address the health needs of the new expansion population. As you know, Louisiana is the first state to expand Medicaid in the Deep South. Previously, Louisiana Medicaid served only pregnant women, children, disabled and the extreme poor (at 12% of the federal poverty level (FPL). When we expanded Medicaid on July 1, for the first time adults aged 19-64 living at 138% of the federal poverty level, had access to healthcare coverage. In just two months, under the pioneering leadership of Secretary Gee, we've enrolled more than 300,000 new adults, who didn't have healthcare coverage before. I don't believe any other state has been able to expand Medicaid this rapidly, in such a short time span. This is a population that we hadn't really cared for in the past. Now, our thinking had to expand beyond pregnancy and childhood health, to adult chronic diseases, cancer prevention, adult behavioral health, and the prison population. And we had to do it rapidly. All while also proactively addressing the Zika threat sweeping the southern gulf states and respond to the devastating flooding in Louisiana. So it's been a fast learning curve. But I've been blessed with an incredibly talented team. They are truly the ones who've enabled us to nimbly tackle the challenges and proactively advance innovation during this first year. I am so grateful to get to serve the people of this great state, and work towards achieving a Healthy Louisiana!

3. What is your focus/passion? (Industry related or not)

My focus is healthcare quality. All my work, designing a health information exchange, developing health quality performance metrics, implementing health initiatives; they all are aimed ultimately towards the end goal of improving quality to healthcare. In Louisiana, we've made tremendous

strides in improving access to healthcare through Medicaid Expansion. Having access to healthcare is the first step. However, the next step is to ensure that people don't just have access, but have access to quality healthcare. Ultimately, moving the needle on health quality is the end goal.

And we are seeing progress in moving towards a healthier Louisiana. In just the first two months since we expanded Medicaid, among the expansion population more than 1,000 women have gotten breast cancer screening or diagnostic imaging, among which 24 are being treated for breast cancer. Among this new expansion population, there have been nearly 700 colon cancer screening or diagnostic scopes, with 112 patients undergoing polyp removals. That's 112 colon cancers averted. We've had nearly 12,000 patients receive preventive healthcare or new patient services. These are just among the newly enrolled patients. We're also working on designing a comprehensive Health Information Technology strategy that promotes widespread adoption of EHR, enables connectivity and sharing of data, and promotes transparency in this data. These are just first steps, but a journey begins with those first steps.

4. What is the top item on your "bucket list?"

I would love to one day go on an extended medical mission trip. I've never actually done a real, full time medical mission trip. During the recent flooding in Louisiana, I spent much of my time at the various shelters helping to coordinate medical relief efforts at the shelters. It was the amazing volunteer medical professionals from our community, as well as through the Red Cross and the National Public Health Service who provided direct patient care. But on occasion, I'd get to actually sit down with a few shelterees and hear their stories. They told about literally losing everything; from family photos to their whole home being gutted by the flood waters. But what I kept seeing throughout all these stories was a thread of resilience and compassion. One woman in a wheelchair talked about how another person in the shelter helped her get needed supplies, as she had difficulty navigating her way on her own in the shelter. Another person told me how they had lived through both Katrina, Gustav and now the "Great Flood", and simply said, "I'm starting over again." These stories of resilience, courage and compassion are what nourish the soul and define our humanity. They also keep me grounded and remind me of where I come from.

I myself lived in shelters when I was a young child, after we escaped from Cambodia and the Killing Fields. It was during this time in the Cambodian border refugee shelters that my family was injured by errant RPG explosives. A volunteer Red Cross Surgeon operated on my mother and me, saving our lives. I never learned his name, but that volunteer surgeon inspired both my sister and me to go into medicine. For me, it truly does hit home to see how medical mission volunteers can make such a

tremendous impact in people's lives. So one day, from my bucket list, I'd love to join a medical mission trip and work, not as a health official or administrator, but as a surgeon.

5. What do you enjoy doing most with your personal time?

I enjoy writing. I'm very much an amateur, but practice makes better. As my sister and I were growing up, my mom would retell us incredible stories about our family's life in the Cambodian Killing Fields. She shared stories about extraordinary acts of compassion, about having courage in the face of evil, and unrelenting faith that enables hope during the darkness of a bloody genocide. My mom, a small, humble woman, taught me so much about courage and hope. She truly has the heart of a tiger. Later, while I was studying at Yale, I visited the Yale Genocide Project, which made me realize how important it was to write down these stories, so they don't get lost. So in my spare time, I write down the stories my mother shared, and weave into them my own experiences as a refugee, a patient, and a surgeon. My goal is that through sharing these stories I can inspire hope. The message I would share is that no matter how challenging your circumstances are, never, ever give up.

6. Who is your favorite historical figure and why?

John Lewis. I heard John Lewis speak when I was working as a Kaiser Family Foundation health policy intern for Senator Tom Harkin. I still remember his vivid stories about his boyhood growing up on a sharecropper's farm in rural Alabama, where he honed his oratorical skills preaching to his pet chickens, and first practiced nonviolence protesting his parents cooking those same chickens! It was amazing to hear the humble origin stories of this giant in the Civil Rights movement.

7. What is your favorite junk food?

Peanut M&M's and chocolate chip mint ice cream. Actually, any kind of ice cream is great!

8. Of what accomplishment are you most proud?

I'm always very happy, and a little bit proud, whenever I convince my patient to quit smoking. I know it's challenging, and people often think why would a surgeon care about smoking? That seems like a primary care issue. However, smoking is one of the main reasons why some of my patients need surgery, and it affects the ability of my patients to recover after surgery. Whenever I have to perform an amputation for a gangrenous diabetic leg, or for complications of severe peripheral vascular disease, it always feels like a failure. I always wish I could have prevented my patient's disease from progressing to that point. And preventive care, such as smoking cessation counseling,

diabetes treatment and prevention, and hypertension management, all contributed to that amputated leg. So even though it seems like a small win, every time I get a patient to quit smoking, I feel so happy and, yes, proud. I still have a photo of the package of Winstons that one patient handed over as he agreed to quit. The fact is, we have to think about health on both the individual level, as well as the population level. That is why, since we expand Medicaid in Louisiana, and now have the opportunity to care for this 19-64 year old adult population for the first time, preventive care is so critical as we work to move the needle on healthcare.

9. For what one thing do you wish you could get a mulligan?

If I could do things over, get a mulligan in life, I think I'd be braver about taking chances. When two roads diverge, don't be afraid to take the one less traveled. When I decided to become a surgeon, I had no idea how I would fit healthcare policy, into a surgical career. Since I was young, I'd always known that I wanted to work in some form of public service, and after working in Washington DC, I had a passion for healthcare policy, but I didn't see how those would fit with surgery. However, during my medical school clerkships, I fell in love with wielding the scalpel. There was no place I loved more than being in the operating room. I had no idea how I would integrate these different passions, but I took a leap of blind faith and decided to do what I loved, and went into a surgical residency. However, there was a great deal of doubt and worry as to how it would all work out. I would tell my younger self, don't be afraid. Just do what you love, and be brave.

10. What are the top 1-3 issues that you think will be important in Medicaid during the next 6 months?

1. *Access to Quality Healthcare*
2. *Meaningful HIT which helps us achieve quality healthcare*
3. *The opioid epidemic and how we proactively and thoughtfully address it*

GREATER BATON ROUGE

Business Report



Forty Under 40 Q&A: SreyRam Kuy

November 23, 2016

Dr. SreyRam Kuy, recently honored with Business Report's Forty Under 40 Award, was profiled in Business Report. Read the full interview here: <https://www.businessreport.com/article/forty-40-qa-sreyram-kuy>



SreyRam Kuy, 38

Chief Medical Officer of Medicaid, Louisiana Department of Health

As a very young child in 1980, SreyRam Kuy found herself in a refugee camp in Thailand after her family fled the genocide being committed in her native Cambodia. After she and her mother were severely injured by errant rocket-propelled grenades, volunteer doctors operated on them, saving their lives. It marked the first step in Kuy's journey toward becoming a doctor helping underserved populations. Her family arrived in America in the early 1980s, and Dr. Kuy came to Baton Rouge after being named Chief Medical Officer of Medicaid in Louisiana in May. In her short time here, Dr. Kuy has already helped Louisiana become the first state to develop a Zika prevention strategy for pregnant Medicaid patients.

NAME THREE MAJOR PROFESSIONAL ACCOMPLISHMENTS.

As Chief Medical Officer for Louisiana Medicaid I'm proud that for the first time women with breast cancer have access through Louisiana Medicaid to contralateral breast reconstruction. In addition, cancer affected individuals and those at high risk for breast or ovarian cancer now have access to BRCA 1 and BRACA 2 mutation testing. I am deeply committed to providing women with access to early diagnosis and quality treatment for breast cancer. For me, this is really important on a public health level because Louisiana has one of the highest cancer mortality rates in the nation.

On a professional level, this comes back full circle to where I started 16 years ago as a Kaiser Family Foundation Health Policy Scholar working for Senator Tom Harkin in Washington D.C., writing Senator Harkin's speech in support of the Breast and Cervical Cancer Prevention and Treatment Act. Congress passed this important act in 2000, allowing women in the U.S. diagnosed with breast and cervical cancer to access treatment through Medicaid. It is satisfying to now, as a part of Louisiana Medicaid, be able to expand upon those services at a state level. These new policies allow genetic testing for conditions that are hereditary so patients can make informed

decisions about their plan of care; and now women who required a mastectomy as part of their treatment can have reconstructive surgery on the opposite breast as well; improving physical and psychological outcomes for these women.

On a personal level, twenty years ago my own father died from cancer and now my mother is a survivor of cancer. I've seen firsthand as the child of cancer patients how devastating this disease process is. Now, as a general surgeon, I can draw upon those personal experiences as I care for my own cancer patients and their families. I am honored as a surgeon to have the opportunity to share the compassion and empathy that my family and I experienced during our own journey with cancer.

So for me, my work as a surgeon caring for cancer patients, as a healthcare advocate and as a health policy maker, is personal. It's less about accomplishments, but more about "Paying it Forward."

TELL US ABOUT YOUR VOLUNTEER & COMMUNITY AFFILIATIONS AND INVOLVEMENT.

Much of what I do is inspired by my mother. Growing up very poor, our family didn't have a lot materially. My mom couldn't afford to buy Christmas gifts or birthday gifts for our family. But we always felt loved, and my mom still found ways to help others who were even needier than us. She shared home cooked meals and warm clothes with a blind, elderly woman in our town. She bought school uniforms for children and helps support girls in third world countries to get access to an education. My sister, Dr. SreyReath Kuy, and I try to continue my mom's traditions. Last Christmas, instead of buying a tree and presents, we hosted a benefit for NOMI Network, an organization combatting human trafficking. We raised \$3,350 that night. Just a miniscule drop in the bucket when you consider the magnitude of the problem with 32 million trafficked people fueling a \$99 billion dollar industry. However, my mom taught me that it isn't the magnitude of the problem that matters but the willingness of our heart to do something, to do anything. This year I received a community service award from the Ford Family Foundation, and as a result was able to donate \$5,000 to help veterans at the New Orleans Veterans of Foreign Wars Post. As a surgeon who cared for veterans, I've seen the challenges many of our veterans face. I truly appreciate their sacrifices for the freedoms we enjoy. If anything, I hope this small seed grant will help draw attention to the tremendous need among veterans and encourage others to donate, volunteer or find other ways to serve the veterans in our community.

I've been blessed with wonderful mentors throughout my career. As a result, I love mentoring the next generation of doctors, medical students, and college students. Some of them shadow me throughout the year, others come and spend a summer, and some are long distance tele-mentoring relationships via phone and email. I've also volunteered as an instructor for Mini-Med, a program through Louisiana State University that educates the general public about medical topics. I really enjoyed teaching non-medical members of the community, who ranged from accountants to department store sales clerks, lawyers to radio hosts about health. It's amazing the insightful perspectives I get from my students and the lay public. I realized that when I teach, I learn so much along the way.

In the medical community, I served as a volunteer Board Member on the National Board of Medical Examiners. The NBME governs licensing for all medical doctors in the United States through a series of examinations designed to test knowledge and competency of doctors. As a Board Member, I helped guide the NBME in its budgetary decisions, future direction of the licensing exam, and incorporating new topics such as professionalism and diversity in medicine. I also served as a volunteer member on the Accreditation Council for Continuing Medical Education. The ACCME governs continuing education for all U.S. physicians, and as part of this volunteer committee we meet to review the different organizations providing continuing medical education to doctors. I

believe being a part of the process that ensures our healthcare providers continually learn about new practices of care is important for promoting good quality of care for all patients. I've also served as vice-chair of the Association for Women Surgeons Communications Committee, member of the Association of Academic Surgeons Information and Technology Committee, Membership Committee and Program Committee, and on the American College of Surgeons National Diversity Committee.

NAME ONE BOOK THAT HAS INSPIRED YOU PROFESSIONALLY.

How Will You Measure Your Life? by Clay Christensen

WHEN YOU WERE A CHILD, WHAT DID YOU WANT TO BE WHEN YOU GREW UP?

My passion for medicine began in a refugee camp, birthed as a casualty from war. The doctor who saved my life in Khao-I-Dang was the first step of my journey into medicine. I've known for as long as I can remember that I wanted to be a doctor, and in particular, to work with underserved populations. My own memories of those experiences are lacking, but the story of my family's flight from Cambodia's Killing Fields is woven into the fiber of my being, formed from my mother's frequent retellings of our history and the scars that we carry as daily reminders. After escaping from Cambodia, my family and I fled to Khao-I-Dang refugee camp in 1979. We thought we were safe, but we were wrong. Just weeks after our arrival, we were severely injured by errant RPG explosives. A volunteer Red Cross surgeon operated on my mother and me, saving our lives. After a year and a half of migrating between four different refugee camps, we were resettled in the United States. Though we left behind the clamor of warfare in Cambodia for the idyllic college town of Corvallis, my mother inculcated in my sister and me a deep appreciation for the blessing of being alive; and it is this gratitude that drives my passion for medicine and caring for vulnerable populations.

As a surgeon, I cared for veterans, a number of whom struggle with PTSD, poverty and substance abuse. War is savage, and witnessing it is brutal, whether you're a child or a soldier, and its ramifications linger. With these obstacles, I sometimes wonder what difference do we actually make in the lives of our patients? One veteran came into the E.R. with a diabetic gangrenous leg, which we had to emergently amputate to save his life. A year later, he came back, severely ill from uncontrolled diabetes. He had severe lung disease as a result of years of smoking and congestive heart failure. He now had an infection of the remaining leg, which had progressed to gangrene, causing a systemic disruption of his body called sepsis. His kidneys, his heart and his lungs were shutting down as a result of the infection, and to save his life we would need to amputate his remaining leg. However, it felt futile, remembering the same fight we had fought to just one year ago. He was despondent, and refused surgery despite knowing that this was tantamount to a death sentence.

Sometimes, we look at a problem, and it feels like we are facing an impossible ocean of obstacles. It's easy to ask, "What am I with just my two hands?" However, I've learned that there is a great deal that two hands can accomplish when they are guided by a compassionate heart.

A year ago I presented a medical lecture and I chatted afterwards with an audience member who told me his story. He had spent several months in the Khao-I-Dang border camps taking care of Cambodian refugees as a young doctor in 1979. This was the same camp where my family lived during that time. It must have seemed futile to him as to what he could accomplish in the span of a few months, with little resources beyond his two hands, and a seemingly endless ocean of need, hunger and poverty. It is one thing to bandage a child's wounds, but what impact does one person actually have on a future already battered by genocide, political conflict, and starvation? He showed

me photos of a sea of brown faces; Cambodian children giddily grinning for an American stranger's camera. Over the years, he had looked at these pictures and often wondered what happened to the children that he taken care of, and questioned what impact, if any, he had made. Then he smiled at me, as if to say that now he knew.

What I learned from this chance encounter is that we have the capacity to impact people's lives, even when our resources are few and the needs are overwhelming. We often don't see the results of our efforts. But sometimes, decades later, we may be surprised. The surgeon who saved my life in Khao-I-Dang was the first step of my journey in medicine. To him I am deeply indebted. Because of that doctor, what I value most about being a surgeon is the opportunity to express that gratitude through another patient's life, whether or not I ever see the results of those efforts.

After a series of heart to heart talks, my patient eventually agreed to undergo surgery and I took him to the operating room for an emergency amputation. With the infection controlled, slowly his lungs, heart and kidneys began recovering. Long term, he faces a sea of challenges. The effort is on patient education and with social work to help him continue his medication regimen and resume his much needed preventive primary care treatments. My work was just one small step. However, I'm grateful to have the opportunity to help start that small step.

WHAT WAS YOUR FIRST JOB, HOW OLD WERE YOU AND WHAT DID YOU LEARN FROM IT?

Arriving in the U.S. as immigrants, my parents were just grateful to have the opportunity to work and to start a new life. My mom was willing to do anything honest to support my sister and me, even if that meant holding down two to three jobs at a time. In the evenings, after she finished her janitorial job at the hospital, my mom cleaned houses for doctors and professors in town. And my sister and I would go along and help with dusting, mopping and cleaning toilets. On weekends we went with my dad to help mow lawns and weed yards. In the summers when school was out, we worked in the fields of the Willamette Valley alongside migrant farm workers, picking strawberries, blueberries, raspberries, green beans, onions, garlic, tomatoes, boysenberries, and even a berry called black cats. What I learned from that job was don't eat black cats! They may look like cute little black raspberries, but they taste like ink! Which is what they're used to make. And ink does not taste good! Second, I learned that an opportunity to work is an opportunity. We all have to start somewhere. And I'm so grateful for the opportunities I've had.

WHAT IS THE STRANGEST JOB YOU'VE EVER HAD?

My strangest job was working as a surgery intern. On my first day as a brand new doctor, I was sent to pronounce a deceased patient. Another day, I plucked maggots out of a gangrenous leg.

WHAT DO YOU CONSIDER YOUR GREATEST ACHIEVEMENT?

I'm always very happy, and a little bit proud, whenever I convince my patient to quit smoking. I know it's challenging, and people often think why would a surgeon care about smoking? That seems like a primary care issue. However, smoking is one of the main reasons why some of my patients need surgery, and it affects the ability of my patients to recover after surgery. Whenever I have to perform an amputation for a gangrenous diabetic leg, or for complications of severe peripheral vascular disease, it always feels like a failure. I always wish I could have prevented my patient's disease from progressing to that point. And preventive care, such as smoking cessation counseling, diabetes treatment and prevention, and hypertension management, all contributed to that amputated leg. So

even though it seems like a small win, every time I get a patient to quit smoking, I feel so happy and, yes, proud. I still have a photo of the package of Winston's that one patient handed over as he agreed to quit. The fact is, we have to think about health on both the individual level, as well as the population level. That is why, since expand Medicaid in Louisiana on July 1 under the pioneering leadership of Secretary Gee and Governor Edwards, we now have the opportunity to care for this 19-64 year old adult population for the first time. Preventive care is a critical component of our success as we work to move the needle on healthcare.

HOW DO YOU GET PUMPED UP BEFORE A BIG MEETING, PRESENTATION OR PITCH?

I usually go somewhere quiet and say a little prayer. I pray before every surgery I do and before every important meeting.

WHAT HAS BEEN THE MOST FULFILLING MOMENT IN YOUR CAREER SO FAR?

It was extremely fulfilling to see more than 20,000 people get preventive healthcare or new patient services in just three months since Louisiana Medicaid expansion occurred. In addition, more than 1,700 women were able to get breast cancer imaging. Another 1,200 patients got colon cancer screening. And among those patients, 270 had colon polyps removed. These were potential colon cancer cases averted, because patients had access to healthcare coverage through Medicaid expansion. Knowing this makes my work feel very fulfilling.

WHAT IS YOUR BEST PRODUCTIVITY HACK?

Finding good people. That's my productivity secret! I've been blessed to have amazing staff to work with. People who are committed and passionate about their work. Any successes I've had in the operating room are due to the compassionate nurses, technicians and OR staff who work so hard and go above and beyond for our patients. Any successes I've had in my role as Medicaid's chief medical officer, I owe to the phenomenal staff who work there. Their dedication and talent amazes me. Good people are my productivity hack.

WHAT HAVE YOU LEARNED THE HARD WAY?

Just because someone says it can't be done, doesn't mean you shouldn't try.

WHAT ABOUT YOUR JOB WOULD SHOCK CUSTOMERS OR CLIENTS IF THEY KNEW ABOUT IT?

I do "musical pimping" in the operating room. Surgical culture has a long tradition of something called "pimping the student". Which is where the attending surgeon rapid fires a series of successively challenging anatomy, technique or obtuse surgical history interrogation questions until the medical student is reduced to a quivering mass of incoherent jelly. I'm not very good at medical pimping, so instead I do musical pimping; where I ask the student what song is playing on the radio,

and who sings it. Once, my patient who was awake under local anesthesia, joined in on the fun and got every single musical question right throughout the whole surgery! But, he did pick the radio station himself, and being a golden oldies station, he may have had an unfair advantage!

HOW DO YOU TYPICALLY DRESS FOR WORK—CASUAL? PROFESSIONAL? BUSINESS CASUAL? OTHER?

On surgery days, I usually just roll out of bed and come to work in whatever, knowing I'll be in scrubs for the rest of the day. Wearing scrubs is wonderful—it feels like being in your pj's all day! At the Medicaid office I can't wear pajamas to work. So usually I'll stick to something professional.

WHAT PART OF YOUR JOB DO YOU LOVE? WHAT PART DO YOU HATE?

The part I love about my job is knowing that we're truly making a difference in people's lives by getting them access to timely, quality healthcare. The challenge about my work is that as a state Louisiana ranks 50th in the country for overall health. I hate that. But I believe this challenge is an opportunity. We have the chance to seize this opportunity and through a focus on healthcare quality truly move forward to a healthy Louisiana.

HOW MANY TEXTS DO YOU SEND ON AN AVERAGE DAY? HOW MANY EMAILS?

Texts: 50. Emails: 100

WHAT TIME DO YOU GET UP ON WORKDAY MORNINGS?

5 a.m.

BREAKFAST AT HOME? BREAKFAST ON THE GO? BREAKFAST AT YOUR DESK? NO BREAKFAST AT ALL?

On the go.

WHEN DID YOU REALIZE YOU WERE “GROWN UP”?

The first time I did an E.D. thoracotomy. An E.D. thoracotomy is a last ditch effort done when a patient loses their vital signs. This one was especially heart wrenching; an 8 year boy who had been shot by his father. Cracking open this little boy's chest in the chaotic emergency room, and squeezing this small heart with my hand as we wheeled his stretcher towards the operating room, I knew that I would never forget this day again.

FAVORITE GIFT YOU WERE GIVEN AS A CHILD?

My Bible. Pastor Paulson at Grace Lutheran Church gave me my first bible in third grade, and I still have it. It's dog eared, taped up together, and missing a few pages, but still good.

WHICH TALENT OR SUPERPOWER WOULD YOU MOST LIKE TO HAVE AND WHY?

I would love to be able to fly.

WHAT'S A NICKNAME YOUR FRIENDS OR FAMILY MEMBERS HAVE FOR YOU?

Sunshine!

WHO FASCINATES YOU?

My mother fascinates and inspires me. As my sister and I were growing up, my mom would tell us incredible stories about our family's life in the Cambodian Killing Fields. She shared stories about extraordinary acts of compassion, about having courage in the face of evil, and unwavering faith that enables hope during the darkness of a bloody genocide. My mom, a small, humble woman, taught me so much about courage and hope. She truly has "The Heart of a Tiger"! Later, while I was studying at Yale, I visited the Yale Genocide Project, which made me realize how important it was to write down these stories, so they don't get lost. So in my spare time, I wrote down the stories my mother shared into a book, "The Heart of a Tiger", and wove into them my own experiences as a refugee, a patient, and a surgeon. My goal is that through sharing these stories I can inspire hope and courage. My mom's story is a story of unrelenting resilience. At the heart of it, "The Heart of a Tiger" is a message that no matter how challenging your circumstances are; never, ever give up.

WHICH FICTIONAL CHARACTER DO YOU MOST IDENTIFY WITH?

Anne Shirley from *Anne of Green Gables*. She's so plucky, and never gives up.

WHAT IS YOUR FAVORITE BAND OR SONG?

Amazing Grace.

WHAT IS YOUR FAVORITE MOVIE?

Shawshank Redemption.

WHO WOULD PLAY YOU IN A MOVIE?

Reese Witherspoon. She is an amazingly talented actress, producer, and so plucky. She produces great movies about incredibly strong women. It's great to see these intelligently made films that inspire and uplift.

IF YOU COULD GO BACK IN TIME, WHAT ADVICE WOULD YOU GIVE YOUR 18-YEAR-OLD SELF?

If I could go back in time, I would tell my younger self to be braver about taking chances. When two roads diverge, don't be afraid to take the one less traveled. When I decided to become a surgeon, I had no idea how I would fit healthcare policy into a surgical career. Since I was young, I'd always known that I wanted to work in some form of public service, and after working in Washington D.C., I had a passion for healthcare policy, but I didn't see how those would fit with surgery. However, during my medical school clerkships, I fell in love with wielding the scalpel. There was no place I loved more than being in the operating room. I had no idea how I would integrate these different passions, but I took a leap of blind faith and decided to do what I loved, and went into a surgical residency. However, there was a great deal of doubt and worry as to how it would all work out. If I could go back in time, I would tell my younger self, don't be afraid. Just do what you love, and be brave.

HAVE YOU HAD ANY MEMORABLE CELEBRITY ENCOUNTERS? WHAT HAPPENED?

I'm definitely not cool enough to get to meet celebrities! However, I did meet Dick Guttman, the author of *Starflacker*, which draws from his sixty years representing legends in Hollywood and shares stories about hard work, humility and compassion—uncommon adjectives in Tinsel town. Dick described how “Clint Eastwood can't stand not being expert at anything he tries, including making the jump from pistols to pianos.” Dirty Harry would play the piano until his fingers bled. That kind of passion is truly the differentiator of success; it shows that “luck takes a lot of hard, smart work.” Another interesting star that Dick represents is Jay Leno, a brilliant comedian with a quiet humility despite his extraordinary success. When Jay got his star on the Hollywood Walk of Fame, he didn't choose a spot in a posh part of Hollywood. Instead, he chose an inconspicuous location in front of the Ripley's Believe It or Not museum. This was the location where Jay was picked up on charges of vagrancy when he first arrived in California as a poor, unknown, aspiring comic. That night, the police officers drove Jay around all night while he entertained them, until they finally dropped him off without being booked. He's come a long way since his arrival in Los Angeles as a young unknown, but Jay humbly continues to share his talents, now helping veterans such as Corporal Ethan Laberge. Laberge, while on duty in Afghanistan, was seriously wounded by a suicide bomber. Jay surprised the veteran with a test drive in a new Dodge SRT Hellcat and then gifted the surprised soldier the car afterwards. Jay's humility, and his work to draw attention to the needs of our veterans, are truly commendable. Barbra Streisand is another larger than life superstar who uses her celebrity status to bring attention to worthy causes by investing in women's health. Barbra learned that heart disease is one of the biggest killers of women after her friend died from heart failure. Out of her grief grew her compassion; leading her to start the Barbra Streisand Heart Center which plays a leading role in investigating how heart disease manifests differently in women. From Dick's stories about Clint, Jay and Barbra, I learned lessons about hard work, humility and compassion.

WHAT GIVES YOU THE MOST HOPE ABOUT THE FUTURE?

There is so much reason to have hope about the future. I've seen the incredible resilience of the human spirit. And that gives me reason to have hope.

WHAT WOULD BE YOUR ADVICE FOR FUTURE FORTY UNDER 40 HONOREES?

My advice would be "Never, ever give up!"

DO YOU HAVE A BUCKET LIST? IF SO, WHAT ARE THE TOP 3 THINGS ON IT?

I would love to one day go on an extended medical mission trip. I've never actually done a real, full time medical mission trip. During the recent flooding in Louisiana, I spent much of my time at the various shelters helping to coordinate medical relief efforts at the shelters. It was the amazing volunteer medical professionals from our community, as well as through the Red Cross and the National Public Health Service who provided direct patient care. But on occasion I'd get to actually sit down with a few people living in shelters and hear their stories. They told about literally losing everything; from family photos to their whole home being gutted by the floodwaters. But what I kept seeing throughout all these stories was a thread of resilience and compassion. One woman in a wheelchair talked about how another person in the shelter helped her get needed supplies, as she had difficulty navigating her way on her own in the shelter. Another person told me how they had lived through Katrina, Gustav and now the "Great Flood", and simply said, "I'm starting over again." These stories of resilience, courage and compassion are what nourish the soul and define our humanity. They also keep me grounded and remind me of where I come from.

I myself lived in shelters when I was a young child, after we escaped from Cambodia and the Killing Fields. It was during this time in the Cambodian border refugee shelters that my family was injured by errant RPG explosives. A volunteer Red Cross Surgeon operated on my mother and me, saving our lives. I never learned his name, but that volunteer surgeon inspired both my sister and me to go into medicine. For me, it truly does hit home to see how medical mission volunteers can make such a tremendous impact in people's lives. So one day, from my bucket list, I'd love to join a medical mission trip and work, not as a health official or administrator, but as a surgeon.

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/12/2016 1:08:45 AM
To: Jennifer Lee (b) (6) [redacted]@gmail.com]
Subject: Re: O'Rourke - for your call

No problem- glad i knew -cause i mentioned to him

Sent from my iPhone

On Nov 11, 2016, at 5:35 PM, Jennifer Lee (b) (6) [redacted]@gmail.com> wrote:

Oh! Sorry! His staffer called me yesterday on this topic so i assumed this was why he was calling...?

On Nov 11, 2016 2:26 PM, "David shulkin" <Drshulkin@aol.com> wrote:

It wasnt that

Sent from my iPhone

> On Nov 11, 2016, at 12:37 PM, Jennifer Lee (b) (6) [redacted]@gmail.com> wrote:

>

> Hi David,

> Beto is likely calling to enlist your support in getting "Vet Connect" passed through the Senate in the lame duck session.

> As you know, Beto was the primary sponsor of Vet Connect which passed the House in late September. This bill enables VA to share protected health information with other providers (esp Choice) without the Veteran specifically having to authorize it. We had an additional restriction on data sharing in Title 38 which this bill would address. This bill would be a huge help to us in improving health information exchange!

> Beto's staffers reached out to SVAC and think they are interested. They would like to have a high level meeting with SVAC member and/or staff to see if we can get this done.

> Ash has been helping drum up support quietly on SVAC too.

> Let me know if you would like more info?

> Thanks

> Jen

>

Message

From: Jennifer Lee (b) (6) @gmail.com]
Sent: 11/11/2016 10:35:41 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: O'Rourke - for your call

Oh! Sorry! His staffer called me yesterday on this topic so i assumed this was why he was calling...?

On Nov 11, 2016 2:26 PM, "David shulkin" <Drshulkin@aol.com> wrote:

It wasnt that

Sent from my iPhone

> On Nov 11, 2016, at 12:37 PM, Jennifer Lee (b) (6) @gmail.com> wrote:

>

> Hi David,

> Beto is likely calling to enlist your support in getting "Vet Connect" passed through the Senate in the lame duck session.

> As you know, Beto was the primary sponsor of Vet Connect which passed the House in late September. This bill enables VA to share protected health information with other providers (esp Choice) without the Veteran specifically having to authorize it. We had an additional restriction on data sharing in Title 38 which this bill would address. This bill would be a huge help to us in improving health information exchange!

> Beto's staffers reached out to SVAC and think they are interested. They would like to have a high level meeting with SVAC member and/or staff to see if we can get this done.

> Ash has been helping drum up support quietly on SVAC too.

> Let me know if you would like more info?

> Thanks

> Jen

>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/11/2016 10:26:01 PM
To: Jennifer Lee [REDACTED]@gmail.com]
Subject: Re: O'Rourke - for your call

It wasnt that

Sent from my iPhone

> On Nov 11, 2016, at 12:37 PM, Jennifer Lee [REDACTED]@gmail.com> wrote:
>
> Hi David,
> Beto is likely calling to enlist your support in getting "Vet Connect" passed through the Senate in the lame duck session.
> As you know, Beto was the primary sponsor of Vet Connect which passed the House in late September. This bill enables VA to share protected health information with other providers (esp Choice) without the Veteran specifically having to authorize it. We had an additional restriction on data sharing in Title 38 which this bill would address. This bill would be a huge help to us in improving health information exchange!
> Beto's staffers reached out to SVAC and think they are interested. They would like to have a high level meeting with SVAC member and/or staff to see if we can get this done.
> Ash has been helping drum up support quietly on SVAC too.
> Let me know if you would like more info?
> Thanks
> Jen
>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/11/2016 6:11:27 PM
To: Jennifer Lee [REDACTED]@gmail.com]
Subject: Re: O'Rourke - for your call

Perfect

Sent from my iPhone

> On Nov 11, 2016, at 12:37 PM, Jennifer Lee [REDACTED]@gmail.com> wrote:

>

> Hi David,

> Beto is likely calling to enlist your support in getting "Vet Connect" passed through the Senate in the lame duck session.

> As you know, Beto was the primary sponsor of Vet Connect which passed the House in late September. This bill enables VA to share protected health information with other providers (esp Choice) without the Veteran specifically having to authorize it. We had an additional restriction on data sharing in Title 38 which this bill would address. This bill would be a huge help to us in improving health information exchange!

> Beto's staffers reached out to SVAC and think they are interested. They would like to have a high level meeting with SVAC member and/or staff to see if we can get this done.

> Ash has been helping drum up support quietly on SVAC too.

> Let me know if you would like more info?

> Thanks

> Jen

>

Message

From: Jennifer Lee [REDACTED]@gmail.com]
Sent: 11/11/2016 5:37:20 PM
To: David Shulkin [drshulkin@aol.com]
Subject: O'Rourke - for your call

Hi David,

Beto is likely calling to enlist your support in getting "Vet Connect" passed through the Senate in the lame duck session.

As you know, Beto was the primary sponsor of Vet Connect which passed the House in late September. This bill enables VA to share protected health information with other providers (esp Choice) without the Veteran specifically having to authorize it. We had an additional restriction on data sharing in Title 38 which this bill would address. This bill would be a huge help to us in improving health information exchange!

Beto's staffers reached out to SVAC and think they are interested. They would like to have a high level meeting with SVAC member and/or staff to see if we can get this done.

Ash has been helping drum up support quietly on SVAC too.

Let me know if you would like more info?

Thanks

Jen

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/11/2017 2:47:43 PM
To: [REDACTED] [REDACTED]@aol.com]
BCC: [REDACTED] [REDACTED]@gmail.com]
Subject: Re: Lunch

Absolutely

I'll ask [REDACTED] to find a time

Sent from my iPhone

> On Jan 11, 2017, at 9:38 AM, [REDACTED] [REDACTED]@aol.com> wrote:
>
> David,
> Hope all is well. How about lunch next week?
> [REDACTED]
>
> Sent from my iPhone

Message

From: (b) (6) (b) (6)@hotmail.com]
Sent: 1/15/2017 11:11:17 PM
To: Marisol Garcia [(b) (6)]@frenchangel59.com]
CC: David shulkin [Drshulkin@aol.com]
Subject: Re: Breakfast on Thursday, January 19, 2017 at 9:30 AM

Thanks Marisol! We are Looking forward to it.

Sent from my iPhone

On Jan 15, 2017, at 6:05 PM, Marisol Garcia <(b) (6)@frenchangel59.com> wrote:

(b) (6) and Doctor David Shulkin,

Please block your calendars for breakfast with Laurie and Ike Perlmutter on Thursday, January 19, 2017 at 9:30 AM.

Restaurant:

BLT Prime By David Burke (Trump International Hotel)

Address: 1100 Pennsylvania Avenue NW, Washington, D.C. 20004

Phone: 202-868-5100

The following people will join you:

Marsha and Doctor Bruce Moskowitz

Barbara and John Turitzin

Best,

Marisol

Message

From: (b) (6) (b) (6) PARTNERS.ORG]
Sent: 1/7/2017 4:26:55 PM
To: IP (b) (6)@frenchangel59.com]; (b) (6) (b) (6) @jhmi.edu]; Bruce Moskowitz [bruce(b) (6)@mac.com]; (b) (6) @ccf.org; (b) (6) M.D. (b) (6) @mayo.edu]
CC: David shulkin [drshulkin@aol.com]
Subject: Re: Scheduled meeting today

Great. He sounds superbly qualified, I have never met him. I guess a big question would be whether he is interested in presiding over the plan we discussed or would want to head in a different direction.
Regards, torch

On Sat, Jan 7, 2017 at 11:20 AM -0500, "Bruce Moskowitz" <(b) (6)@mac.com> wrote:

Dr Shulkin is on schedule to meet with Reince Priebus at one and President elect Donald Trump at two today. I will keep everyone updated on the progress of the meeting.

Sent from my iPad
Bruce Moskowitz M.D.

The information in this e-mail is intended only for the person to whom it is addressed. If you believe this e-mail was sent to you in error and the e-mail contains patient information, please contact the Partners Compliance HelpLine at <http://www.partners.org/complianceline> . If the e-mail was sent to you in error but does not contain patient information, please contact the sender and properly dispose of the e-mail.

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 12:15:42 AM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Fwd: Dr. Shulkin - Satellite Media Tour
Attachments: image001.png; Untitled attachment 25019.htm; VA Jan 12 SMT update-- 1-9-17.docx; Untitled attachment 25022.htm; VA Jan 12 SMT update-- 1-9-17.docx; Untitled attachment 25025.htm

Omg

Sent from my iPhone

Begin forwarded message:

From: "Wright, Vivieca (Simpson)" (b) (6) @va.gov>
Date: January 9, 2017 at 6:09:30 PM EST
To: "David shulkin (Drshulkin@aol.com)" <Drshulkin@aol.com>
Subject: FW: Dr. Shulkin - Satellite Media Tour

From: (b) (6)
Sent: Monday, January 09, 2017 4:37 PM
To: Ridley, Sharon G.; Lieberman, Steven; (b) (6) (b) (6) Wright, Vivieca (Simpson)
Cc: Hyduke, Barbara; (b) (6) (b) (6) (b) (6)
Subject: RE: Dr. Shulkin - Satellite Media Tour

All –

We now have a total of 18 interviews scheduled for Thursday. New interviews are highlighted.

From: (b) (6)
Sent: Friday, January 06, 2017 4:49 PM
To: Ridley, Sharon G.; Lieberman, Steven; (b) (6) (b) (6) Wright, Vivieca (Simpson)
Cc: Hyduke, Barbara; (b) (6) (b) (6) (b) (6)
Subject: Dr. Shulkin - Satellite Media Tour

All –

Here is the updated information regarding the medical centers in the cities scheduled.

Thanks.

(b) (6)
Acting Executive Director
Office of Communications
Veterans Health Administration
Department of Veterans Affairs
Office: (b) (6)
Cell: (b) (6)



VA Core Values: Integrity Commitment Advocacy Respect Excellence

VA Core Characteristics: Trustworthy | Accessible | Quality | Innovative | Agile | Integrated



Satellite Media Tour Schedule 1-9-17 4:32 pm update

Client: U.S. Department of Veterans Affairs

Topic: Same Day Services and 2017 VA updates

Spokesperson: Under Secretary for Health, Department of Veterans Affairs Dr. David Shulkin

Date: Thursday, January 12, 2017; 7a-12pm

TIME (ET)	OUTLET	MARKET	FORMAT	HOST	SHOW NOTES	VAMC
7:30a	WBZ-AM (RADIO)	Boston	Taped	Deb Lawler	#1 NewsTalk	Boston, Bedford, Northhampton
7:40a	Sirius XM Radio (RADIO)	National	LIVE	Tim Farley	The Morning Briefing on SiriusXM's POTUS Ch. 124	
7:50a	KTBC-FOX	Austin	Live	TBD	KTBC Fox Austin News	Houston Michael E. DeBakey VA Medical Center
8:10a	WRAZ-FOX	Raleigh	Live	TBD	FOX 50 News	Durham
8:30a	WTLV-ABC	Jacksonville FL	TBD	TBD	First Coast News	North Florida/South Georgia Veterans Health System, Tampa, Orlando
8:50a	WGN-AM (RADIO)	Chicago	Taped	Steve Cochran	The Steve Cochran Show, #1 Talk station	Lovell FHCC (N. Chicago), Jesse Brown, Illiana HCS (Danville), Hines
9:00a	KRLD-AM (RADIO)	Dallas	Taped	Mitch Carr	KRLD News, Dallas NewsTalk	Dallas VA North Texas HCS
9:10a	KTSA-AM (RADIO)	San Antonio	Taped	Bill O'Neil	KTSA News	South Texas Veterans HCS
9:20a	WGHP-FOX	Greensboro	Live	TBD	WGHP FOX8 News	Fayetteville Asheville

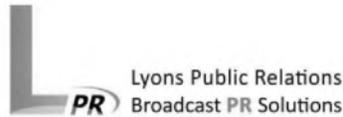
Commented [SG1]: New Interview – but the name of the facility had already been provided for research

Commented [SG2]: New Interview – but the name of the facility had already been provided for research



Lyons Public Relations
Broadcast PR Solutions

9:45a	KGUN-ABC/CW	Tucson, AZ	Live to Tape	TBD	Morning Blend	Southern Arizona HCS / Tucson, AZ
9:50a	TWC Raleigh	Raleigh	Taped	Caroline	TWC Raleigh (feeds affiliates across state)	Durham
10:00a	FOX NewsEdge	National	Taped	Alison	Feeds all Fox Affiliates nationally	
10:15a	KING-NBC	Seattle	Live	TBD	KING Morning News	Seattle, WA Puget Sound HCS
10:40a	KOB-TV	Albuquerque, NM	Live to Tape	Casey Messer (female)		New Mexico HCS
10:23a	WCHM-NBC	Columbus, OH	Live to Tape	Robyn	WCHM News	Columbus VAMC
10:50a	KDAF-CW	Dallas	Taped	TBD	Eye Opener	Dallas VA North Texas HCS
11:00a	WTWO-NBC	Terre Haute	Taped	TBD	WTWO News	Richard L. Roudebush VA Medical Center (Indianapolis VA Medical Center)
11:10a	WTKR-CBS	Norfolk	Live to Tape	TBD	WTKR News	Hampton, Salem



Satellite Media Tour Schedule 1-9-17 4:32 pm update

Client: U.S. Department of Veterans Affairs

Topic: Same Day Services and 2017 VA updates

Spokesperson: Under Secretary for Health, Department of Veterans Affairs Dr. David Shulkin

Date: Thursday, January 12, 2017; 7a-12pm

TIME (ET)	OUTLET	MARKET	FORMAT	HOST	SHOW NOTES	VAMC
7:30a	WBZ-AM (RADIO)	Boston	Taped	Deb Lawler	#1 NewsTalk	Boston, Bedford, Northhampton
7:40a	Sirius XM Radio (RADIO)	National	LIVE	Tim Farley	The Morning Briefing on SiriusXM's POTUS Ch. 124	
7:50a	KTBC-FOX	Austin	Live	TBD	KTBC Fox Austin News	Houston Michael E. DeBakey VA Medical Center
8:10a	WRAZ-FOX	Raleigh	Live	TBD	FOX 50 News	Durham
8:30a	WTLV-ABC	Jacksonville FL	TBD	TBD	First Coast News	North Florida/South Georgia Veterans Health System, Tampa, Orlando
8:50a	WGN-AM (RADIO)	Chicago	Taped	Steve Cochran	The Steve Cochran Show, #1 Talk station	Lovell FHCC (N. Chicago), Jesse Brown, Illiana HCS (Danville), Hines
9:00a	KRLD-AM (RADIO)	Dallas	Taped	Mitch Carr	KRLD News, Dallas NewsTalk	Dallas VA North Texas HCS
9:10a	KTSA-AM (RADIO)	San Antonio	Taped	Bill O'Neil	KTSA News	South Texas Veterans HCS
9:20a	WGHP-FOX	Greensboro	Live	TBD	WGHP FOX8 News	Fayetteville Asheville

Commented [SG1]: New Interview – but the name of the facility had already been provided for research

Commented [SG2]: New Interview – but the name of the facility had already been provided for research



Lyons Public Relations
Broadcast PR Solutions

9:45a	KGUN-ABC/CW	Tucson, AZ	Live to Tape	TBD	Morning Blend	Southern Arizona HCS / Tucson, AZ
9:50a	TWC Raleigh	Raleigh	Taped	Caroline	TWC Raleigh (feeds affiliates across state)	Durham
10:00a	FOX NewsEdge	National	Taped	Alison	Feeds all Fox Affiliates nationally	
10:15a	KING-NBC	Seattle	Live	TBD	KING Morning News	Seattle, WA Puget Sound HCS
10:40a	KOB-TV	Albuquerque, NM	Live to Tape	Casey Messer (female)		New Mexico HCS
10:23a	WCHM-NBC	Columbus, OH	Live to Tape	Robyn	WCHM News	Columbus VAMC
10:50a	KDAF-CW	Dallas	Taped	TBD	Eye Opener	Dallas VA North Texas HCS
11:00a	WTWO-NBC	Terre Haute	Taped	TBD	WTWO News	Richard L. Roudebush VA Medical Center (Indianapolis VA Medical Center)
11:10a	WTKR-CBS	Norfolk	Live to Tape	TBD	WTKR News	Hampton, Salem

Message

From: (b) (6) (b) (6)@gmail.com]
Sent: 11/16/2016 4:24:03 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: David Shulkin Presentation on 11-15-2016

(b) (6)

----- Forwarded message -----

From: (b) (6) (b) (6)@gmail.com>
Date: Wed, Nov 9, 2016 at 5:42 PM
Subject: Re: David Shulkin Presentation on 11-15-2016
To: (b) (6) (b) (6)@gmail.com>

 Shulkin. InteragencySlides11.15 - JMC edits 201...

Good evening (b) (6)

Please see link attached with Dr. Shulkin's presentation with videos embedded in the ppt. The video will not open in a different window, it will flow with the presentation. If you have any questions, please let me know.

V/r

(b) (6)

On Tue, Nov 1, 2016 at 2:17 PM, (b) (6) (b) (6)@gmail.com> wrote:

Good Afternoon (b) (6) please let me know if you received this PowerPoint, with 3 videos that will need to be tested for sound and internet quality at the venue.

(b) (6)

On Tue, Nov 1, 2016 at 10:48 AM, (b) (6) (b) (6)@gmail.com> wrote:

Good Morning,

Please find attached Dr. David Shulkin's presentation on 11/15/2016 at 9am. Please note there 3 separate videos on slides 3,20,25. Please confirm that there will be sound and internet available and if you can test the videos before hand.

Thanks,

(b) (6)

Message

From: Poonam Alaigh (b) (6) @hotmail.com]
Sent: 12/4/2016 7:01:02 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: updated HBS update

yes- lets discuss

From: David shulkin <Drshulkin@aol.com>
Sent: Sunday, December 4, 2016 1:57 PM
To: Poonam Alaigh
Subject: Re: updated HBS update

Ok we can do this- or if you want to we can think about submitting our own article

Sent from my iPhone

On Dec 4, 2016, at 1:45 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

David, the HBS study did not include this attachment- I am thinking of using this for our Pitt project. If you have a chance, want a quick brainstorm with you regarding using that study to tell our story more, and maybe for the researchers to get your perspective directly. Let me know when you have time for a quick call and develop a more expanded and inclusive version of the above- need to use this strategically and include some key players at the VA.

From: Poonam Alaigh (b) (6) @hotmail.com>
Sent: Sunday, December 4, 2016 1:36 PM
To: Poonam Alaigh
Subject: Fw: updated HBS update

From: Alaigh, Poonam (b) (6) @va.gov>
Sent: Sunday, December 4, 2016 1:34 PM
To: (b) (6) @hotmail.com
Subject: FW: updated HBS update

From: Alaigh, Poonam
Sent: Tuesday, November 15, 2016 4:25 PM
To: Blackburn, Scott R.

Cc: Lieberman, Steven

Subject: FW: updated HBS update

Scott, please see attached more information on MyVA Access which is a critical part of the transformation legacy and would be so insightful the HBR.

Feel free to contact me or Steve for additional information including giving the Prof my cell phone number.

Thanks a ton- really appreciate your flexibility and accommodation of this key legacy element!!

From: Lieberman, Steven

Sent: Tuesday, November 15, 2016 2:04 PM

To: Alaigh, Poonam

Subject: updated HBS update

<HBS update2.docx>

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/4/2016 6:57:24 PM
To: Poonam Alaigh (b) (6) @hotmail.com]
Subject: Re: updated HBS update

Ok we can do this- or if you want to we can think about submitting our own article

Sent from my iPhone

On Dec 4, 2016, at 1:45 PM, Poonam Alaigh (b) (6) @hotmail.com> wrote:

David, the HBS study did not include this attachment- I am thinking of using this for our Pitt project. If you have a chance, want a quick brainstorm with you regarding using that study to tell our story more, and maybe for the researchers to get your perspective directly. Let me know when you have time for a quick call and develop a more expanded and inclusive version of the above- need to use this strategically and include some key players at the VA.

From: Poonam Alaigh (b) (6) @hotmail.com>
Sent: Sunday, December 4, 2016 1:36 PM
To: Poonam Alaigh
Subject: Fw: updated HBS update

From: Alaigh, Poonam (b) (6) @va.gov>
Sent: Sunday, December 4, 2016 1:34 PM
To: (b) (6) @hotmail.com
Subject: FW: updated HBS update

From: Alaigh, Poonam
Sent: Tuesday, November 15, 2016 4:25 PM
To: Blackburn, Scott R.
Cc: Lieberman, Steven
Subject: FW: updated HBS update

Scott, please see attached more information on MyVA Access which is a critical part of the transformation legacy and would be so insightful the HBR.

Feel free to contact me or Steve for additional information including giving the Prof my cell phone number.

Thanks a ton- really appreciate your flexibility and accommodation of this key legacy element!!

From: Lieberman, Steven

Sent: Tuesday, November 15, 2016 2:04 PM

To: Alaigh, Poonam

Subject: updated HBS update

<HBS update2.docx>

Message

From: Poonam Alaigh (b) (6) [redacted]@hotmail.com]
Sent: 12/4/2016 6:45:02 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: updated HBS update
Attachments: HBS update2.docx

David, the HBS study did not include this attachment- I am thinking of using this for our Pitt project. If you have a chance, want a quick brainstorm with you regarding using that study to tell our story more, and maybe for the researchers to get your perspective directly. Let me know when you have time for a quick call and develop a more expanded and inclusive version of the above- need to use this strategically and include some key players at the VA.

From: Poonam Alaigh (b) (6) [redacted]@hotmail.com>
Sent: Sunday, December 4, 2016 1:36 PM
To: Poonam Alaigh
Subject: Fw: updated HBS update

From: Alaigh, Poonam (b) (6) [redacted]@va.gov>
Sent: Sunday, December 4, 2016 1:34 PM
To: (b) (6) [redacted]@hotmail.com
Subject: FW: updated HBS update

From: Alaigh, Poonam
Sent: Tuesday, November 15, 2016 4:25 PM
To: Blackburn, Scott R.
Cc: Lieberman, Steven
Subject: FW: updated HBS update

Scott, please see attached more information on MyVA Access which is a critical part of the transformation legacy and would be so insightful the HBR.

Feel free to contact me or Steve for additional information including giving the Prof my cell phone number.

Thanks a ton- really appreciate your flexibility and accommodation of this key legacy element!!

From: Lieberman, Steven
Sent: Tuesday, November 15, 2016 2:04 PM
To: Alaigh, Poonam
Subject: updated HBS update

Since 2014, in spite of the identified challenges with access to outpatient services in VA, Veteran demand for care continued to increase. From FY2014 to FY2016, the number of appointments made within VA increased by approximately three million appointments, from 55,034,727 to 57,960,937. During this same time frame, community based appointments also rose by an estimated 5.3 million appointments from 15,789,588 to an estimated 21,053,723*.

In July 2015, when Dr. Shulkin joined the VA as the Under Secretary of Health, he identified the first challenge to be the inability to identify patients with the highest and most urgent clinical needs. He tasked his senior leadership to take on different tactics to simplify our business processes. This included consolidation of the over 30 different ways of scheduling a specialist consult to two ways, classifying the appointment as either stat or routine. This resulted in identifying around 56,000 stat consults waiting greater than 30 days. He executed an emergent call to action with a national Stand Down in November 2015 and in February 2016. Each of the 166 medical centers contacted the targeted Veterans on the wait lists, triaged them for their clinical needs and connected them with the appropriate services. Around the time of the stand-downs, VA also implemented a standardized process for facility staff to review in real-time, referrals to specialty care with more immediate needs. These efforts led to a reduction of Veterans waiting over 30 days to see a specialist for the first time for a more immediate need from approximately 56,000 in November 2015 to less than 600 as of mid-November 2016.

While this was an immediate approach to fixing the crisis, there was a recognition that a more foundational, systemic and sustainable approach needed to be developed. Dr. Shulkin therefore established the MyVA Access initiative in December 2015 to drive and coordinate enterprise-wide approaches to improving Veteran access to care. He also appointed a Senior Advisor, Dr. Poonam Alaigh as the Executive Sponsor for Access to work with a field led, field focused multidisciplinary team largely comprised of subject matter experts from VA medical centers including the two co-chairs who were sequestered together in Washington, D.C. for four weeks. This work group was tasked to identify a road forward to propel the changes needed with access to care. They identified a 3 pronged approach as below:

- Prong 1- MyVA Access Declaration - a firm commitment to foundational principles and represent nine declarative principles that support the collective commitment to our Veterans that serve as a pledge regarding Veterans ability to access care in a timely manner. (Exhibit 15).
- Prong 2- MyVA Access Implementation Guidebook - This team studied best practices within VA and outside VA to improve access and also studied recommendations from prior internal and external reviews dating back to 2003 that identified access barriers for Veteran access to care within VA. The team identified the 20 most impactful and most feasible solutions that would bring about needed change and also assist facilities with achieving the MyVA Access Declaration Statements.
- Prong 3- MyVA Access Deployment –implemented a national deployment strategy that entailed deployment of teams to each facility. This comprised of system redesign experts from the VA Veterans Engineering Resource Center as well as subject matter experts to assist facilities with redesigning their health care delivery systems with implementation of access solutions via rapid cycle improvement efforts. VA also provided two national training endeavors to best prepare medical center champions for the changes that were needed across VA.

As part of our commitment to meet the urgent needs of patients, VA medical centers have also been instituting programs to ensure that when care is need right away that same day services in primary care and mental health are available. Depending upon the urgency, their need may be met by providing a

face to face visit, returning a phone call, arranging a telehealth or video care visit, responding by secure email or scheduling a future appointments. As of October 31, 2016, 86 medical centers had instituted same day services. It is anticipated that all 166 medical centers across VA will have instituted same day services in primary care and mental health by December 31, 2016.

VA is continuously improving operations to further reduce the number of Veterans with more immediate needs waiting for care. VA has increased the number of physicians by 11.2% and the number of nurses by 11.9%. Every VA also appointed at least one group practice manager whose responsibility is to optimize outpatient healthcare administration. VA has activated 2.6 million new square feet for patient care and supporting activities and increased direct patient care hours by approximately 7.4 million hours, an estimated 11% increase in physician productivity. Finally, Dr. Shulkin created a permanent Office of Veterans Access to Care to ensure our veterans get access to care at the right time, in the right way in a Veteran centric culture. This office is led by an executive-level Assistant Deputy Undersecretary of Health for Access to Care, Dr. Steven Lieberman, and is solely focused on implementing key access principles system-wide via the deployment of leading clinical, IT, administrative and other innovative solutions.

All of this is resulting in transformative change with a seismic cultural shift in VA. Early results are showing progress with sustainable improvements. While more work is needed, focusing on Veterans with urgent needs remains VA's highest priority.

**Due to a lag of three to four months between the provision of the service and payments date, the number of community care appointments for the last quarter of FY 2016 had to be estimated based on monthly trended averages.*